06-0*5*+*3*5 Patricia Ann Davis

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		For State		Certificate of Death					Reg. No. 2000 100				1000		
Physiciar Medical Examin	1/	. Decedent's Name (First, Midd	ecedent's Name (First, Middle,Last) Patricia					Davi	s		Date of De Month May 21 , 2	Day	Year		of Death
Ivicultal Examini		la. Facility Name (if not institution	n, give s	treet and nu		Ann	4t	D. City, Town, or L	ocation of		iviay 21, 2		County of	Death A	
A .		1729 E. 33 rd. Street						Baltimore	Less :	201	0. D. I (D				
Funeral Director	1	5. Social Security Number 253–04–5384	6. Sex	1 2 X F	7. Age (In	yrs. last birt	hday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.		02 –1 9:	1	 Birthplace Foreign Country) 	Ga.
	-	Jsual Residence of Decedent	, L., 14	2 _A		40	110.				12	02 13.	<i>51</i>		- Ca.
any		I0a. State 10b. County			100	. City, Town	or Locatio	n		-				10d. In	side City Limits
Pi wi		Md.	N	A			Baltir	nore						1 📑	of Yes 2 No
Maryland 28a-f show any datonce.	읈	I0e. Street and Number					T	10f. Zip Code				10g. Citize	n of Wha	at Country?	
he Mi	Director	1729 E. 33r	d s	treet				212	18				US	A	
with t		11. Marital Status	1	12. Was Dec		r in U.S.		Decedent of Hisp				lo- 14		American Indi	an, Black,
rdeath with the Maryland or items 23a or 28a-f sho must be notified at once	Funeral	1 Never Married 2 M	larried	Armed F	orces?	No	It Ye	s, specify Cuban,	Mexican,	Puerto Ri	can, etc.)		White,	etc	
after o	칡	3 Widowed 4 Div	orced If	Yes, Give Yea	ar	`		Yes 2 X No					oecify:	Blacl	ζ
hin 72 hours after than "natural", than "natural", edical Examiner		15. Decedent's Education (Spe						s Usual Occupations st of working life. I				16b. Kin	nd of Bus	iness/Industry	
36 in 72 ban "	Completed	Elementary/Secondary (0-12)		College (Cosn	netology				S	e]f−F	Employe	5-d
-000 with giene her tl	E	12th grade 17. Father's Name (First, Middle	Last)	2y:	rs.				8.Mother's	Name (F	irst, Middle				
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Bec	Ernest	. ,			Thor	nas			Mar	tha		I	Russell	
212 buld b buld b Meni marli		19a. Informant's Name/Relations	ship (Typ	e, Print)		19	b. Mailing	Address (Street	and Numb	oer or Ru	ral Route Nu	umber, City	or Town	, State, Zip Co	ide)
MD 12 sho th and 27 is		Bernie Davis		Ηυ	ısban			9 E. 33							1218
Fe, land land Heal		20a. Method of Disposition 1 XBurial 2 Crematio	n 3	Removal f	rom State		of Disposit tory or oth	ion (Name of cem er place)	etery,	ı	Date	20c. Lo	cation - (City or Town, S	State
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene trant: If item 27 is marked other than "natural", or other tranmatic event, the Medical Examiluer.		4 Donation 5 Other S		Removari	TOTAL OLDING	Garr	rison	Forest	Vet.	5-30	0-06	Ov	wing.	s Mills	, Md.
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Ī	21 Sign sure of Funeral Service	License	e),//	11	1		ame and Address			Balti	more,	Md.	21202	
	4	Soseth F	W. 1	Mal	turs	SY		arch F.						th Ave	
Physician /Medical		2 P int I. Enter the disease, o failure, List only one cause	e on eact	n line.		-								Betv	veen Onset and
xaminer	1	Immediate Cause (Final disease condition resulting in death)		Acute e			.catio	n complicat	ing h	ypert	ensive	cardio	vascu	lar pise	asë "
	1		b.	ue to (or as	a consequ	erice or).									
	je.	Sequentially list conditions, if any, leading to immediate		ue to (or as	a consequ	ence of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	С.	ue to (or as	a consequ	ence of):				_	_			\rightarrow	
760, Teate be executed physician and the burial - transit		events resulting in death) Last	d.												
e executed cian and rial - transi	n/Medical	X UNPENDED		AMENDED	item	[‡] 23a,27	,28a-f	perME,g85	6 , 6/8/	'06 TI	1				
68760, certificate be anding physici	Me	IF FEMALE:				of pregnancy				-			Date of o	-	
687 certific rding se as t	ian/	23b. Was decedent pregnant in past 12 months?	ıne	1 Live			2 Fet		Ectopic	pregnand	су	^	Month	Day	Year
Box e death of the atten	Physiciar	1 Yes 2 No 9 V Ur	nknown	9 Unkr			⊃ Otr	er (Specify)							
ords, P.O. Box 6876 w requires that the death certificat s been signed by the attending phy should be detached for use as the	P.	Part II. Other significant cond	itions o	contributing	to death bu	at not resultir	ng in the u	nderlying cause g	ven in Pa	rt I.	23e. Did	tobacco us	se contrib	oute to the cau	se of death?
P.O	d by										1 🗌 Y	'es 2	No 3	Probably 4	1 V Unknown
rds requir	Completed										24a. Wa	as an opsy			ndings available ion of cause of
e law te has	m					·-						formed?	de	eath? Yes	2 No
tal Rec	ပိ	25. Was case referred to medic	al					26.Place	of Death (Check or			<u> </u>	<u> </u>	
Vital ysician: his certiff director,	o Be	examiner? 1 ✓ Yes 2 No	_	spital: 1	Inpatient	2 ER/0	Outpatient	3 DOA	Other4	Nursing	Home 5	Residen	ce 6 🗸	Other: Scene)
1 of Jing Ph	\vdash	27. Manner of Death		28a. Dat	e of Injury th, Day,Year		Time of Ir	njury 28c. Injur	y at Work	? 2	8d. Describ	e how injury	y occurre	ed	
ion tendii eath	atio		nding estigation	Fnd 5	5,/21/20		1 5:05	AM 1 Y	es X	^{No} u	nk				
Division of Vital Records, pital or Attending Physician: The law require ours after death erral Director: After this certificate has been stilled in by the funeral director, page 2 should be a page 3 sho	ertification:	3 Suicide 6 X Co	uld not b	e 28e. Pla			farm, stree	t, factory, office b	uilding, etc	c. 2				r or Rural Rou 33rd St	te Number, City
Dj spital tours 2 filled	Cert	4 Homicide	ermined	(0,000)	-						Ltimor	œ, MD_			
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Functral Director: After this certificate has been signed by the attercompletely filled in by the funeral director, page 2 should be detached for use the funeral director, page 2 should be detached for a	Medical		aminer:	On the basis	s of examir			red at the time, da ion, in my opinion,							e(s)
To To Com	Med	29b. Signature and title of certi		and manner	stated.			29c. License	e number		-	29d. Da	ate signe	ed (Month, Da	y, Year)
		QuoD	· ·					O.C.I	νi.Ε.			May	21, 20	06	
		30. Name and address of person	on who co	ompleted ca	use of dea	th (Item 23a)									
0,				t Medical				treet, Baltimo	re, MD	21201					
296	ate	31. Date filed (Month, Day, Yea	Date filed (Month, Day, Year) 32. Fee					de							
Regist	rar	MAIZ:) // UU	D A	Color	A AND	135,00	-							

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F rtificate of			Reg. No.	2006	16502
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day		3. Time of Death 3:10 AM
1	/Medic	al	Catharine Dages 4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Deat	May	22 4c.	2006 County of Death	3.10 11
	Examin	er	6806 Bellona Ave.	,		Baltin				Baltimon	ce
	Funeral		Social Security Number 6. Security Number	7. Age	(In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	ay, Year)	Coun	ace (State or Foreign
	Director		334-26-4036	JW 5771	72 Yrs.			Decembe	er 24,	1933	Illinois
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10	Od. Inside City Limits
	Many a-f ah	to	Maryland Baltimo	re	Baltimor	e					1 ☐ Yes 2 XNo
	or 284	Jirec	10e. Street and Number			10f. Zip Code			-	zen of What Coun	-
	ath w	rai	6806 Bellona Ave.	10 111 - 0 1 - 1		21212	00.40			ited Stat	
336	be filed within 72 hours after death with the Maryland stal Hyglene. Id other than "natural", or Itema 23a or 28a-f ahow event, The Madical Examinar must be incitified at	by Funeral Director	11. Marital Status 1 Married 2 Married 3 Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 2 N If Yes, Give Year or Dates:	to 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No		opecity Yes or No to Rican, etc.)		Black, White, of Specify:	
Ö	72 hou	ted	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occup	pation	rkina	16b. Kir	nd of Business/Inc	lustry
21215-0036	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	kind of work done DO NOT use retire		i king	mini	iatru/ao	cial work
2	led w tygier har th	S	17. Father's Name (First, Middle, Last)	4	Lati	olic sis		me (First, Middle	1		STAL WOLK
_	m = 0 5	o Be	Omer Francis Dages					et Rose			
Ž	shoul nd Me mark	ပို	19a. Informant's Name/Relationship (Ty		19b. Mail	ing Address (Street					Code)
Ĭ	alth a alth a 27 is		Judith Waldt, MHSH,	/personal		1 W. Joppa		Cowson,	MD 2	21204	
ore	of He of He fitam		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	св)	Date	20c. Lo	cation - City or To	wn, State
altimore,	Pag tment tant:		4 ☐ Donation 5 ☐ Other (Specify)		New Cathe					timore, l	
Ba	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic as QDG.		21. Signature of Funeral Service Licens Order Of Mittel	POPE	2	2. Name and Addre Mitche 6500	ell-Wiede	efeld Fu	neral	Home	Inc.
		П	23a. Part1. Enter the disease, or complete shock, or heart failure. List only o	lications that caused	the death. Do not er	iter the mode of dyi	ng, such as cardia	c or respiratory a	arrest,	1110 212	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition		Unocarci					astatic ,	Onset and Death
1	/Medical		resulting in death)	Due to (or as	a consequence of):		0				0
	Examiner	L	Sequentially list conditions, if any, leading to immediate	b. — Due to /or on	2 consequence of/:						
7	led Islt	nine	Cause (Disease or injury	Due to (or as	a consequence of):						
V.	and and al-trai	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):						
68760,	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	dical		d					-		
	artifica ing ph e as th		IF FEMALE:								
Boo	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	□Ectopic pregnanc	y		2	23d. Date of delive Month	ry Day Year
P.O. Box	y the d	by Physician/M	1 ☐ Yes 2 ♥ No 9 ☐ Unknown	9☐ Unknown	umo or death 5	Other (specify)					
۳.	signed by	y Ph	Part II. Dther significant conditions co	ntributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.	23e. Did	tobacco u	se contribute to th	e cause of death?
rds	w require been sig should b	ed b	Breast Cancer,	hypertin	sim			1 🗆	Yes 2	No 3□ Prob	ably 4 □Unknown
eco	law re es be 2 sho	piet		0				24a. Was	psy		psy findings available
œ æ	The page	Completed						perf 1 ☐ Yes	ormed?	death?	2 No
Vita	ician; sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		. 04	hor	ath (Check only			
of	Physical direction	T.	1 ☐ Yes 2 X No 27. Manner of Death	1 ☐ Inpatie	nt 2 ER/Outpatie	IN SU DOA	4 Nursing r	dome 5 ☐ Res 28d. Describe		Other (Specify	HOSPICE
on	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da)	Yeer) Injury	Wo	rk?]Yes 2 □No	200. 500050	mon inqui	, 00001100	
Division of Vital Records,	Attended of the py the	ifica	3 Suicide 6 Could not be determined	28e. Place of Inju-	ury - At home, farm, s	treet, factory, office			(Street and	d Number or Rura	I Route Number,
Ö	rs after all Dir	Certification:	4 - Homede	Dullding, etc	S. (Specify)			Oily or 10			
	To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	of my knowledge, dea i examination and/or i	th occurred at the to nvestigation, in my	me, date and place opinion, death occi	e, and due to the urred at the time	cause(s) , date and	and manner as st place, and due to	ated. the cause(s)
	vithin o tha	Me	29b. Signature and title of certifier			29c. Licen:	se number			e signed (Month,	•
	->-0		· Patricia a	Annelell	up	02	7209		5	123/20	006
	\cap		30. Name and address of person who c	ompleted cause of d	eath (Item 23a) (Type	, Print)	·	, on bean . c	1115	#4 D 2	-1093
	2		PATRICIA A SAVAD			-S RD SUL	IE LOO L	MITTERNI		100 2	-10-13
	Sta Regist		31. Date filed (Month, Day, Year) MAY 2 5 20	32. Registro	ar's Signature	Carte 1					
DH	MH 17 Rev 1/2	-	MAY Z 5 ZU	Uto Street	w st fg						

28a-f per Mr 6855, 954	24/06dhb Reg. No.	6 16503
	2. Date of Death	3. Time of Death
DAVIS		11:20PM
. n		Death
ge (In yrs. last birthday) If Under 1 Year If Un-	der 24 Hrs. 8. Date of Birth 9.	Birthplace (State or Foreign
78 Yrs. Months Days Hou	rs Min. (Month, Day, Year) MAV II 1928 Z	Country) DERMUDA
100 City Tours or Legation		10d Janida City Limita
	· · OTa ·)	10d. Inside City Limits 1 ☐ Yes 2 📉 No
		· ·
		American Indian,
No 1 ☐ Yes 2 No Spec		P A C 1
		BLACK
(Give kind of work done during r	most of working	essindustry
SALES ASS	OCIATE J. WALKE	R C. JEWELER
18. M		
		NTER
20b. Place of Disposition (Name of		Contract of the Contract of th
	15-20-1/2 1000000	BERMUNE
22. Name and Address of Fa	apility BRALLIN TR. FUNE	RAL HOME
Chamo 3175 N. F.	ILTON AVE, BALTO, A	10.21217
ed the death. Do not enter the mode of dying, such		Approximate Interval Between
ABDOMINAL SERSIS		Onset and Death
	(.	
	-//	4 Pays
WELM IMUNES		4 DISTS
s a consequence of):	A THE BY MEDICAL EXAMINER	
GERHFICATI	A APP KOVED O. III	
1		
2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date o Month	f delivery Day Year
Third of death 3 Other (specify)		
but not resulting in the underlying cause given in Pa	art I. 23e. Did tobacco use contribu	te to the cause of death?
	1 ☐ Yes 2 No 3[Probably 4 Unknown
	24a. Was an 24b. Wer	e autopsy findings available r to completion of cause of
	performed? dea:	th? Yes 2□ No
	lace of Death (Check only one)	
	Nursing Home 5 Residence 6 Other (28d. Describe how injury occurred	Specily)
	Demino collblad	3
ay Year) Injury Work?	X _{No} During Sarring	der surgery
2006 Unknown 1 ☐ Yes 2 njury - At home, larm, street, lactory, office	28f Location (Street and Number of	or Rural Route Number
2006 Unknown ^M 1 □ Yes 2 njury - At home, larm, street, lactory, office atc. (Specify)	28f. Location (Street and Number of City or Town, State Page t	r Aural Aoute Number, Parish Bermu
2006 Unknown 1 □ Yes 2 njury - At home, larm, street, lactory, office etc. (Specify) spita1 t of my knowledge, death occurred at the time, date	28f. Location (Street and Number of City or Town, State Paget King Edward VII) and place, and due to the cause(s) and manner	or Rural Route Number, Parish, Bermu Memorial Hosp or as stated.
njury - At home, larm, street, lactory, office stc. (Specify) spital t of my knowledge, death occurred at the time, date of examination and/or investigation, in my opinion, stated.	28f. Location (Street and Number of City or Town, State Paget King Edward VII) a and place, and due to the cause(s) and manned death occurred at the time, date and place, and	Parish Bermu Parish Bermu Menorial Hosp or as stated. due to the cause(s)
anjury - At home, larm, street, lactory, office stc. (Specify) spital t of my knowledge, death occurred at the time, date of examination and/or investigation, in my opinion, itated.	28f. Location (Street and Number City or Town, State Paget King Edward VII) a and place, and due to the cause(s) and manne death occurred at the time, date and place, and the course of the cause of t	Parish Bermu Parish Bermu Memorial Hosp or as stated. due to the cause(s)
2006 Unknown 1 □ Yes 2 njury - At home, larm, street, lactory, office atc. (Specify) spital t of my knowledge, death occurred at the time, date of examination and/or investigation, in my opinion, stated. 29c. License numb POOS	28f. Location (Street and Number City or Town, State Paget King Edward VII) a and place, and due to the cause(s) and manne death occurred at the time, date and place, and the course of the cause of t	Parish Bermu Menorial Hosp or as stated. due to the cause(s)
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2006 Unknown 1 □ Yes 2 njury - At home, larm, street, lactory, office stc. (Specify) Spital t of my knowledge, death occurred at the time, date of examination and/or investigation, in my opinion, tated. 29c. License numb POS5 death (Item 23a) (Type, Print)	28f. Location (Street and Number City or Town, State Paget King Edward VII) a and place, and due to the cause(s) and manne death occurred at the time, date and place, and the course of the cause of t	Parish Bermu Parish Bermu Menorial Hosp or as stated. due to the cause(s)
	## Ab. City, Town, or Location ## Ab. City, Town, or Location ## Balance ## Ab. City, Town, or Location ## Balance ## Bal	## April Apr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 20b per fh 9855 5-25-06 yt
State of Maryland Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 81.30pm Dliver Ellopree 05 erov. 2006 22 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore NIA Ritchie Joseph Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 05.13. Birthplace (State or Foreign Country) (In yrs. last birthday) 7. Age Social Security Number 6 Sex **Funeral** Min Months Days Hours 62 Yrs. 1**X**M 2□ F 102.34.6531 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County worle ! or then "naturel", or items 23s or 28s-f show the Medical Examinar must be notified at Balti more 1 Yes 2 No MID NIA Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Carver Road 21222 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Marned within 72 hours after Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: ğ 3 ☐ Widowed 4 ☐ Divorced ieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other then Compi Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City unspector 2 years 12th grade treumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be suse Huggins Ellobree John 19a. Informant's Name/Relationship (Type, Frint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice D. Thomas Consin Batto. MD 21218 KNaa DUNWOOD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 31°-06 Owing Mills MD 0 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Garnson permit. Page Department of Important: If any injury or page. 31.00 05. tonest 4 □ Donation 5 □ Other (Specify) 23. Name and Address of Facility Vaughin C. Greene Funeral Services 4905 York Road Baltimore MD 21212 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on e. ch line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) ettending physicien Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy õ in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No this certificate has been signed by the eral director, page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Yes 2 W Attending Physician: After this certification 25. Was case referred to dical Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 3 other (Specky Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Mann of Death Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation To the Hospitel or Attend within 24 hours after death. To the Funerel Director: A 2 Accident the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License numbe 29d. Date signed (Month, Bay, Year) 29b. Signature and little of certific d cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature Year State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

ROSEMARY

Physician

/Medical

Examiner

Funeral Director

2

Be Completed

Examiner

Physician/Medical

Funeral

Director

1 and 2 should be filed within 72 hours effer death with the Maryland Heatth and Mental Hygiene. Set 1 show and 27 is marked other than "natural", or Items 23a or 28a-f ahow

ment of Health a rich flew 27 is.

permit. Page Department (important: If any injury or once.

Physician

Maryland 21215-0036

Baltimore,

2006

24,

BENJAMIN FRANCIS

P.O.

Vital

Division of

Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at

requires that the death certificate be executed page 2 should be detached The law certificate hes After this certification, i Hospital or Attending Physician: death. the within 24 hours after deatl To the Funeral Director: completely filled in by the

that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Be 25. Was case referred to medical 26. Place of Death Check only one examiner Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: Certification: To 1 ☐ Yes 2X No 4 ☐ Nursing Home 5 ☐ Residence 6 ②Other (Specify) HOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

10x1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year) State MAY 2 5 2006 Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

Medicai

\$2. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

120

29d. Date signed (Month, Day, Year)

5/25

06-03123 Julius Foster

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate o	of Death	Re	g. No. 200	6 1650
Physicia edical Examir	n/	1. Decedent's Name (First, Middle, Last)	Foster		2. Date of Deat Month May 8, 200	Day Year	3. Time of Death 2237 hrs
and a second		4a. Facility Name (if not institution, give stree Sinai Hospital	at and number)	4b. City, Town, or Location of Deati Baltimore		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 214.75-7250 1 MM	7. Age (In yrs. last birihday)	rs. If Under 1 Year If Under 24Hr. Months Days Hours Mir	- 3/1/	/2000 Foreign	hplace (State or number)
Maryland 28a-f show any d at once.	5	10a State 10b. County	10c. City, Town or Local	imore			10d. Inside City Limits 1 Yes 2 No
the Maryla	Director	2127 N. Fult	ON AVENUE	10f. Zip Code 2/2/7	10	og. Citizen of What Coun	try?
MOFE, MD 21215-0036 Penges I and 2 should be filed within 72 hours after death with the Maryland Pent of Health and Montal Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other tranmatic event, the Medical Examiner must be notified at once.	Funeral		Armed Forces? If	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto		White, etc.	can Indian, 8lack,
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other transmatic event, the Medical Examiner.	eted by	15. Decedent's Education (Specify only hig	tes: 16a. Decede	Yes 2 No specify: ent's Usual Occupation (Give kind of most of working life. DO NOT use rel		Specify: 16b. Kind of Business/Ir	ndustry
5-0036 iled within 7 Hygiene. I other than the Medica	Completed	17. Eather's Name (First, Middle, Leet)		IN Fau +	e (First, Middle, M	laiden Surname)	aut
D 2121 should be find Mental I is marked latic event,	To Be	191 Informant's Name/Relati inship (Type, F	1/0 100	ing Address (Street and Number or	Rural Route Num	ber, City or Town, State,	Zip Code)
Baltimore, MD 21215-00; permit Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other timjury or other transmatic event, the Mec		20a Method of Disposition 8urial 2 Cremation 3 Re	20b Place of Disportment of Communication of Communicatio	osition (Name of cemetery, other place)	Pate 00	20c. Location - City or	Town, State
Baltimore, permit Pages lar permit Pages lar loppartment of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	na Hewa	MR CYTH CMR ten Mame and Address of Facility CYCL	estin	Dalto. 1 veral Ser	vies
Physician /Medical		23a. Part I. Enter the disease, or complication failure. List only one cause on each line		r the mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval 8etween Onset and
Examiner			udden unexplained deat o (or as a consequence of):	th in infancy			Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	o (or as a consequence of):				
ansit	Examine	(Disease or injury that initiated C	o (or as a consequence of):				
760, Tote be executed sphysician and the burial - transit	/Medical		LINDED	,28a-f,perFH,ME,g856,	6/30/06 11		
Box 68760, e death certificate be the attending physici ed for use as the buried	sician	23b Was decedent pregnant in the past 12 months?	Pregnant at time of death 5	Fetal death 3 Ectopic pregn	ancy	23d. Date of delivery Month D	ay Y ear
P.O. Bost that the designed by the a	by Phys	Part II. Other significant conditions contri	Unknown ibuting to death but not resulting in the	e underlying cause given in Part I.		bacco use contribute to t	
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Completed				24a Was a autops perform	24b. Were autoprior to comed? death?	opsy findings available ompletion of cause of
of Vital Recling Physician: The I After this certificate I	0	25. Was case referred to medical		26.Place of Death (Check	1 Yes 2 only one)	No 1 Yes	s 2 No
of Vit ing Physici After this c	To B	examiner? 1 Yes 2 No 27 Manner of Death	i inpatient 2 ERoutpatien			Residence 6 Other:	
ion c ttending leath tor: Af	ation		8a. Date of Injury (Month, Day, Year) nd 5/8/2006 Fnd 6:00		unknown	,.,,,	
Division To the Hospital or Attentwithin 24 hours after death To the Fineral Director:	Certification:	3 Suicide 6 X Could not be 4 Homicide	28e. Place of Injury - At home, farm, str (Specify) found in reside		28f. Location (S or Town, St altimore,	treet and Number or Rur ate) 2127 N. Ful MD	al Route Number, City LON AVENUE
the Ho ithin 24 Fu	edical	one) 2 Medical Examiner: On the	o the best of my knowledge, death occ ne basis of examination and/or investig	-		' '	
E 3 E 8	Me	29b. Signature and title of certifier	manner stated	29c. License number O.C.M.E.		29d. Date signed (Mon May 9, 2006	th, Day, Year)
T		30. Name and address of person who comple	eted cause of death (Item 23a)				
0 St	ate	Ling Li, MD Assistant Medic	32 Registrar's Signature	eet, Baltimore, MD 21201			
Regist		MAY Z O ZUUD	Bladers In Fig.				

			1 - For State Registrar	State of M	aryland / i	Department of F Certificate of		, 0	ene 1. No. 200	6 16508
	Physic		Decedent's Name (First, Middle, Last MARGARET MAR	Margaret Y GRISSI	M. Gissne VER	er		2. Date of Death Month May 23,	Day Yea	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)			r Location of Death	May 25,	4c. County of De	eath
			108 Cinnamon				ngdon		Harfor	
ì	Funeral Director		213 10 0130	9X 7. Ag ☐ M 2 1 7 7	e (In yrs. last bii 80	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 1925 N	Sirthplace (State or Foreign Country) Maryland
	aryland ehow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location	_			10d. Inside City Limits
	a-f eh	tor	MD Baltin	ore		Carn	ey			1 ∐Yes 2XINo
	death with the Maryland me 23a or 28a-f ehow rmust te rodified at	al Director	10e. Street and Number 9616 Alda Driv	re		10f. Zip Code	21234	10g	Citizen of What	Country?
21215-0036	or its	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cubs 1 ☐ Yes ※XXNo	lispanic Origin? (Spean, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race - Ar Black, Wi Specify:	nerican Indian, hite, etc. White
15-0	72 na	letec	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of workin	g 16	b. Kind of Busines	ss/Industry
12	d withir plene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or !	5+)	Bank Tel.	•		ank	
	be filed stat Hyg od other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name			
ylai	2 should be filed v n and Mental Hygie ils marked other t reumatic event, Ib	P	John J. McI					Kennedy		
, Maryland	ges 1 and 2 should t of Health and Mer if Itam 27 is marke or other treumatic		19a. Informant's Name/Relationship (7 Elizabeth Glass		93	Mailing Address (Street B14 Orbita:				
Baltimore,	ury Ent		20a. Method of Disposition 1 X Y gurial 2 Cremation 3 4 Donation 5 Other (Specify		Parky	f Disposition (Name of ry, crematory or other place Vood Cemeto	ery 5-26		c. Location · City · rkville	or Town, State e, Maryland
Balt	permit. Depertr Import		21. Signature of Funeral Service Licen	adle-	_	22. Name and Address	ss of Facility Ford Road	ANS CHA	PEL OF	MEMORIFS ryland 21234
ı			23a. Part1. Enter the disease, or of my shock, or heart failure. List only	olications that caused one cause on each li	the death. Do	not enter the mode of dyin	g, such as cardiac or	respiratory arrest		Approximate Interval Between
>	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	va	CANCOR				Ponset and Death
	Examiner		- 1	Due to (or as	a consequence	of):				
	n =	ner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	<i>ਤ</i> ੀ):				
/	ecuter and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to for an	a consequence	~4).				
68760,	icate be executed physicien and s the burial-transit	aiE		Due to (or as	a consequence	01).				
687	ifficate g phys as the	edicai		d						
.O. Box	requires that the death certificate be executed een signed by the ettending physicien and hould be detached for use as the burial-transit	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months2 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of d Month	elivery Day Year
٩	res that igned b	by Pr	Part II. Other significant conditions or	ontributing to death b	ut not resulting in	n the underlying cause give	en in Part I.	23e. Did tobac	co use contribute	to the cause of death?
ord	w require been sign	ted	- WIX					1 Yes	2 No 3 1	Probably 4 Unknown
of Vital Records,	ysician: The law is certificete has bidirector, page 2 st	omple	Engh	yvera				24a. Was an autopsy performed	prior to death?	
Vita	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	Hasaitab		011	26. Place of Death		.,	
of	Phys r this ral dir	٦.	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatie		The second second	4 Nursing Flom	e 5 Residenc		ecify) Daughter's
ion	nding ath. r: Afte e fune	atior	Natural 5 Pending 2 Accident investigation	(Month, Da		njury Worl	<br Yes 2 □ No		injury occurred	
Division	after des after des I Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, et	ury - At home, fa c. (Specify)	rm, street, factory, office	28	3f. Location (Stree City or Town, S	at and Number or I State)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Medical C	29a. Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best iner: On the basis of and manner sta	examination an	, death occurred at the tin d/or investigation, in my of	ne, date and place, ar pinion, death occurred	nd due to the caus d at the time, date	e(s) and manner a and place, and di	as stated. ue to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Mor	oth, Day, Year)
	/	100	59	m 10.		1 × 0 × 1	1944	m	M7 23	3,2006
_	15		30. Name and address of person who of	112	<u> </u>	- NONTH CO	laston	ect B.	othinon	a mo alas
	Sta Registi		31. Date filed (Month, Def, Year) MAY 2 5 200	32 Registra	ar's Signature	both	-			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Gloria J. Garnes - Davis 2006 19, 07:36 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Union Memorial Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔭 218.56.075 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Healith and Mental Hygiene.
ant: if team 27 is marked to that then "natural; or itame 23a or 28a-f ehow ury or other traumatic event, its Madical Examinar must be notified as MD Baltimore 1 XYes 2 ☐ No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? estertield Avenue USA 2873 21213 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 MNo Specify: Specify: Black 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Manyland Driver 12th grade

17. Father's Name (First, Middle, Last) Zyears 18. Mother's Name (First, Middle, Maiden Sumame) Willie Mae Willie Alston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyedra Garnes 2500 W. Fayede Street

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date Battimore MD 21223 Daughter 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Park Cemetery 05.24.06 Randallstown, MD permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 29. Name and Address of Ecility Fluncial Services 4905 York Road Baltmore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardionyopathy **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Hypertens:
Due o (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy ormed? certificete 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To this is within 24 hours efter death.

To the Funeral Diractor: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours eft To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29b. Signature and title of certifier

ebeccan 31. Date filed (Month, Day, Year)



29c. License number

1)00613

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registramend Item #12 Per FH G855 5/25/10/60 ata of Death 2. Date of Death 3. Time of Death MAY 20, Day 2006 **Physician** GOLDSTEIN 6:35 A HENRY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PARKVILLE BALTIMORE GENESIS PERRING PARKWAY CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) 01/26/1928 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1√ M 2□ F Days Hours Months N.Y. 132-20-5994 78 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or items 23a or 28e-f show any Injury or other treumatic event, the Madical Examiner must be notified at 900. MD BALTIMORE BALTIMORE 1 Yes 2 No Director 10g. Citizen of Whal Country? 10e. Street and Number 10f. Zip Code 8429 OLD HARFORD ROAD APT. 21234 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 1100 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 No Specify. Specify: WHITE If Yes, Give Year or Dates: þ Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) FEDERAL GOVERNMENT STATISTICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MAURICE **ABRAMOVITZ ISABELLE** COHEN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JUNE GOLDSTEIN / WIFE 8429 OLD HARFORD ROAD APT. C - BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHIZUK AMUNO CONG. 05/24/06 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Intervat Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) END STAGE PARKINSON DISEASE Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 Tyes 2 No 3 Probably 4 MUnknown 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No 1 Yes 2 X No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year)

C

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar 31. Date filed (Month, Day, Year) MAY 2 5 2006

29b. Signature and title of certifier



Ziad MirzaMD

29c. License number

1341901

5/23/2006

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2006 ANNA CATHERINE HEDLEY 6:52 PM /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City. Town, or Location of Death Examiner Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | August 31,1912 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1□M XXF MaryTand 93 219-30-5075 Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or iteme 23a or 28a-f ehow The Medical Examiner must be notified at 1 Yes 2XXVo Director Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6505 Sharon Road 21239 USA Pages 1 and 2 should be filed within 72 hours after death a nent of Health and Mental Hygiene. ant: If item 27 is marked other than "naturel", or iteme 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Pes 21 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes aXXNo Specify: Ď 3 X Vidowed 4 □ Divorced White leted 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest Compl Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Louise Parthree Edward George Olert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Parks Franz DTR 23 Skywood Court Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H Important: If ite eny injury or otl once. 1XXBurial 2 Cremation 3 Removal from State Dulaney Valley Memorial Grdns 5/27/06 Timonium, Maryland □Donation 5 □Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc nature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BOWEL PERFORATION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed HYPOTENSION resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) Records, P.O. been signed by the s should be detached 9□ Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/D/No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 1 Yes 2 2 No 2 ER/Outpatient 3 DOA te of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of De ath 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place. 29a. Certifier Medica Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 46356 hosron 10/0/1551 30. Na e and address of person who completed cause death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON. KHOSROW TABASSI, MARYLAND 21204 M. D. . 31. Date filed (Month, Day, Year) 32. gitrar's Signature State Registrar

			State of Maryland / D 1- State Registrar Amend Ttem #4b Per Phy G855	epartment of Health and N Gestificate of Death		ene g. No.2 0 0 6	16512
	at.	19	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Wilda Rae Hagan		May	23 2006	3:30 A M
1	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
	-	.*	3 Applegate Court 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Randallstown P			hplace (State or Foreign buntry)
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	the h	Funeral Director	Maryland Baltimore Pike	esville 10f. Zip Code	10	g. Citizen of What Co	untry?
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	death	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame Black, Whit	
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Maryland	nd 2 sho alth and 27 is m		3	Applegate Court, Pil			
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Baltimore,	# # # # # # # # # # # # # # # # # # #		21. Signature of Funeral Servic Licens	22. Name and Address of Facility ${ m Th}\epsilon$	e Derrick	C. Jones	F/H, P.A.
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	within To t	Σ	29b. Signature and title of certifie	29c. License number	29	od. Date signed (Mon)	th, Day, Year)
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	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 2 5 2006 32. Registrar's Signature	park			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** May 20, 2006 9:20p Gene P. Johnson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Gilchrist Hospice Towson Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Funeral 1 🔀 M 2 🗆 F Yrs. 1948 Maryland Director 220-46**-**1305 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 7 is marked other then "naturel", or Items 23a or 28e-f show treumatic event, the Mudical Examinar must be notified at 1 ¥Yes 2 ☐ No Directo Baltimore Maryland N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21230 USA Street 4 East Gittings Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 68-73 1 Never Married 2 1 Married Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel, any injury or other treumstic event 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steamship Company General Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Audrey Deems Lloyd Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) A Fast Gittings Street, Baltimore, MD ace of Disposition (Name of Date 20c. Location <u> Gilda Johnson-wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 5/26/2006 Elkridge, MD * 4 ☐ Donation 5 ☐ Other (Specify) ^{22.} Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service Licensee M0/234 23a. Part1. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Esophas Immediate Cause (Final disease or condition resulting in death) 00 Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. First Indexlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performed? 1 ☐ Yes 20 No 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes To the Hospitel or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 ☐ Yes 2 No 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification; 1 Natural 5 Pending investigation after death.

I Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by it 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 125643 2006 6601 N. CHARLES STREET 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aukner MD Dendall 2) Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 2 5 2006

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	1 - State Registrar	d / Department of Health and N Certificate of Death	Reg.	No. ZUUD IDDIL
Physician	1. Decedent's Name (First, Middle, Last)	Y JONES	2. Date of Death Month	Day Year // A M
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Examiner	n i. 11 - 1 - 1 - 1 - 1	Timore Baltimore C	1	to com, or boat.
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
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land w	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Location		10d. Inside City Limits
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215-0036 hin 72 hours after deeth an "naturel", or feme 23 Medical Exercit extracts	3 ☐ Wildowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ Mo Specify:		Specify: Black
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_ ≥ ≥ p ≤ ≥ ±	THERESA JONES Daughter	2632 E. CHASE STREET		
	1 Burial 2 Cremation, 3 Removal from State	Place of Disposition (Name of cometery, crematory or other place)	05/23/06	c. Location - City or Town, State MD.
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Division of Vital Records, P.O. Box 68 rither Hospital or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification; To Be Completed by Physiclan/Medi	IF FEMALE: 23c. If yes, outcome of pregna	ancy		
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ro the vithin of the comple	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
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State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signa	ature	V	
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Funeral	Ħ	5. Social Security Number	6. Sex		7 Age (In yrs	last birthday)	If Under 1		der 24Hrs.	8. Date of Birt	th(MM/DD/YY	N/A	rthplace (State or
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more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other tranmatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	,				10f. Zip Coo	le		10	Og Citizen of	What Cou	ntry?
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mor Pages nent of nmt: If		1 X Burial 2 Crem 4 Donation 5 Other	ation 3 <u> </u>	Removal fro		ING MEM		ARK	05-2	27-06	ВАТЛТ	MORE	, MARYLAND
Baltimore, MI permit Pages I and 2 Department of Health a Important: If item 27 injury or other traum		21. Signature of Funeral Se.		ee	,	22.	Name and Add	ress of Facil	ity				OME P.A.
Physician	_	23a Part I. Enter the diseas	e, or complic	Shons that ca	aused the dear	1	206 W N	ORTH A	VENUE	3			Approximate Interval
/Medical	1	failure. List only one commediate Cause (Final dis	6		ınshot Wou	unds							Between Onset and Death
Examine		or condition resulting in dea	th) D	ue to (or as a	consequence	of):							
	Jer	Sequentially list conditions, if any, leading to immediate		ue to (or as a	consequence	of):							
	Examiner	cause Enter Underlying Ca (Disease or injury that initial events resulting in death) L	ed C.	ue to (or as a	consequence	of):				_			
be executed sician and urrial - transit		eventer recalling in dealth, is	d										
O, be exertised and sicial purial	edical	UNPENDED		AMENDED									
Box 68760 e death certificate b the attending physical for use as the bu	sician/Me	IF FEMALE: 23b. Was decedent pregnan past 12 months?	in the	23c. If yes, of 1 Live b	outcome of pre irth		etal death	3 Ectop	oic pregnanc	у	23d Date Month		y Day Year
OX 6	sicis	1 Yes 2 No 9	Unknown	4 Pregn	ant at time of o	death 5 (other (Specify)						
D.O. Bothat the deded by the detached f	Phy	Part II. Other significant co	nditions o			t resulting in the	underlying cau	se given in F	Part I	23e. Did to	bacco use cor	ntribute to	the cause of death?
Division of Vital Records, P.O ral or Attending Physician: The law requires that the strate death after this certificate has been signed by led in by the funeral director, page 2 should be detacted.	d by									1 Yes	2 🗸 No	3 Prob	pably 4 Unknown
cords, law requir has been s	ompleted							_		24a Was a autop:	sy	prior to d	topsy findings available completion of cause of
tal Rec cian: The k certificate h	Com									perfor 1 Yes 2		death? 1 ✓ Ye	es 2 No
Vital ysician: his certifi director,	æ	25. Was case referred to me examiner?	_	spital.	npatient 2	ER/Outpatier		Other	Nursing I		Residence 6	Otho	r Soono
1 of Viding Physic	٦	1 Yes 2 No 27. Manner of Death		28a Date	of Injury	28b. Time of		Injury at Wor	rk? 28	8d. Describe h	ow injury occu		. Scerie
ision Attendir r death ector: A by the fu	ertification:	1 Natural 5 2 Accident	Pending Investigation	FOUND May 22,		FOUND: 1007 hrs	1	Yes 2	No Si	ubject shot			
JVIS II or Ar after of II Directed in by	rtific	3 Suicide 6	Could not be determined	e 28e. Place		home, farm, str	eet, factory, offi	ce building, e		or Town, St	tate)		ral Route Number, City
Division Division Hospital or Attent 24 hours after death Funeral Director: tely filled in by the	0	4 Momicide 29a. Certifier 1 Certifier			Multi-Fan	nily Apt. edge, death occ	ured at the time	date and n		032 Amber			
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical	(Ollows olly	Examiner:		of examination	and/or investig							
F 3 F 5	Me	29b. Signature and title of c		1				ense numbe	r				nth, Day, Year)
		ulle					0.	C.M.E.			May 23, 2	2006	
5		30. Name and address of pe Ana Rubio MD.		mpleted caus t Medical E			Street, Balti	more, ME	21201				
	ate	31. Date filed (Month, Day,)		87.	egistrar's Signa	ture for	W						
Regis	TIEI.	MAY 2	<u> ZUUD</u>	FREE	The To	17							

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State of Maryland / Department of Health and Mental Hygiene 006

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			1 - State Registrar			Cei	rtificate o	f Death		Reg. No			
ı	Physici /Medic		1. Decedent's Name (First, Middle, La	NES					2. Date of I Month	Death	y Year		ath M
ı	Examir		4a. Facility Name (If not institution, gi Bradford Oaks N				4b. City, Town	or Location of Di Clintor			County of De	George's	
ļ	Funeral Director		245-14-8769	Sex 1 □XM 2 □ F	'. Age (In yrs. 85	last birthday) Yrs.	If Under 1 Year Months Day		Ain. 8. Date of E	Dav. Year)	920 No	othplace (State or Fo Country) rth Carol	reign ina
	death with the Maryland ms 23a or 28a-f show Frant to neither at	tor	Usual Residence of Decedent 10a. State Maryland Prince G	eorge ts	10c. Cit	ty, Town or Lo	p Spring	gs				10d. Inside City Li 1 ☐ Yes 2X	
	with the a or 28	Director	10e. Street and Number 5104 SilverValle	v Way			10f. Zip Code 207			10g. Cit	izen of What C	-	
326	be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, If a Mardical Exarting preset by neither at	by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Deced	es? 2□No 19	40-		Hispanic Origin? Iban, Mexican, Pu	(Specify Yes or fuerto Rican, etc.)	No-	14. Race - Am Black, Wh Specify: W	erican Indian, ite, etc.	
1215-0036	within 72 hou ene. than "natura tre Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-		16a. Deced (Give life.		e during most of red)			ind of Busines	•	
	filed w Hygier Ather tl		12th 17. Father's Name (First, Middle, Las			Fin	ger prin	t Expert	Name (First, Midd			overnment	
Maryland 2		To Be	Julius C. Jones,						ıra Hollo		Sumamer		
lan.	2 sho and I		19a. Informant's Name/Relationship						Rural Route Num				7
Baltimore, I	ss 1 and 2 should of Health and Mer item 27 is marker other traumatic		Allene Jones (Wi		20b. F		sition (Name of matory or other p		Date 1y 24,	-	ngs, Ma ecation - City o	ryland 20 Town, State	/40
Ĕ	Pages ment of ant: If it ury or o		1 X Burial 2 □ Cremation 3 ['4 □ Donation 5 □ Other (Speci	JRemoval from S		ryland	Veteran	s Cem.	2006			, Maryland	d
na Pa	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Lice						Lee Fune ia Ferry			nc. n, MD 2071	35
			23a. Par 1. Enter the disc ase, or conductor, or heart failure. List only	mo 1461 one cause on ea	used the deat	th. Do not ent	er the mode of d	ying, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Deatl	n
	Physician /Medical Examiner		disease or condition resulting in death)	a. Due to (o	r as a conseq	juence of):	20110 0	LING CA	4 when	1)/15	ATE	91341	
٥٥,	be executed sician and burial-transit	ıi Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a conseq								
09/89	n certificate to anding physic use as the k	n/Medicai	23	d							, , , , , , , , , , , , , , , , , , ,		
O. BOX	es that the death cerigned by the attendin be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live bir 4 ☐ Pregna 9 ☐ Unknow	th 2∐Feta ntattime ofd	Il death 3	Ectopic pregnan Other (specify)	су			23d. Date of de Month	livery Day Year	
ecords, P.	The law requires that I ite has been signed by page 2 should be detai	by	Part II. Other significant conditions	contributing to dea	ith but not res	sulting in the u	nderlying cause g	given in Part I.			. /	the cause of death	
I		Completed							24a. Wa aut per 1 ☐ Yes	opsy formed?	death?	utopsy findings avail completion of cause 2 No	able
Vital	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 🔲 In		5B/O		thor	Death (Check only				
lon or	or Attending Physician: ther death. Director: Atter this certific in by the funeral director,	-	27. Manner of Death 12 Hatural 5 Pending 2 Accident investigation	28a. Date of (Month		28b. Time of Injury	28c. Inj	4 Lymursing	g Home 5 Res 28d. Describe			city)	_
UIVISION	iaf or Attendii s after death. al Director: Al ed in by the fu	Certification:	3 Suicide 6 Could not to determined	200. Flace C	f Injury - At ho g, etc. <i>(Specif</i>	ome, farm, str	eet, factory, office	9	28f. Location City or To	(Street and own, State)	d Number or R)	ural Route Number,	
	To the Hospital or within 24 hours after Volte Funeral Directions or completely filled in b	Medical (29a. Certifier (Check only one) Check only	nysician: To the b miner: On the bas and manne	is of examina	owledge, death ition and/or inv	n occurred at the vestigation, in my	time, date and pla opinion, death oc	ace, and due to the courred at the time	e cause(s) , date and	and manner a place, and due	s stated. e to the cause(s)	
	To t with To t	Σ	29b. Signature and title of certifier	1.			29 c. L icer	1943))	29d. Date	e signed (Mont	h, Day, Year)	
	10+1		30. Name and address of person who Frank Ryan MD	1170	1 Livi	ngston	Road #	103 Ft.	Washignt	on, M	ID 2074	4-5126	
	Gte Program	200	31. Date filed (Month, Day, Year) MAY 2 5 200	19	gistrar's Signa	ture	ü						

		For State		State of M	larylar					Menta	al Hygi	ene		
		Registrar 1. Decedent's Name (Fir	st, Middle, Las	st)		C	ertificate	e or L	eatn	2 Da	Re te of Death	g. No. 2	06	
Physicia /Medica		Jack		Clinton			Johnson	n			onth 2	22 20	06	4:55PM
Examine Funeral	er	4a. Facility Name (If not Bultimer () 5. Social Security Number	e Was,	hington	Med.	Cent last birthda	y) If Under	Hen 1 Year	Bud If Under 24 Hr	nje	te of Birth	4c. County	e A	undel
Director	}	219-32-5448 Usuel Residence of Dec	8	XM 2□F	70	Yrs.	Months	Days	Hours Mir	Mar	. 22 ,1	936	Coun	ace (State or Foreign try) MD
GC/C deeth with the Maryland me 23a or 28e-1 ehow tribust be incliffed at	ō		. County	4 4	10c. Cit	y, Town or							11	Od. Inside City Limits
ith the Maryla or 286-1 ehor	Irect	MD A1 10e. Street and Number	nne Aru	ndel		Glen	Burnie 10f. Zip				10	g. Citizen ot W	/hat Coun	1 Yes 2 No
GCCC	a l	905 Prince	ton Ter	race			2	21060				.S.A.		•
The second secon	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 I		12. Was Decedent Armed Forces 1 Yes 2 X If Yes, Give Year or Dates:	?	.S. 13	It Yes, spec		panic Origin? (Mexican, Pue Specify:	Specify Ye rto Rican,	es or No- etc.)		- America k, White, e Whi	etc.
2 15 and a second	Completed	15. I (Specify on Elementary/Secondary	Decedent's Edinly highest grad	ucation de <i>completed)</i> College (1-4or 2	5+)		edent's Usua ve kind of wor DO NOT us efits		on ring most of wo	orking		6b. Kind of Bu		
nd 212 be filed with lai Hygiene. d other ther	BeC	17. Father's Name (First,	Middle, Last)			Dene	IILS	-	8. Mother's Na	ımə (First,		ocial S aiden Surname		ıty
arylan should be and Mental or marked or umartic even	Lo	Alonzo Clir									tilda			
C = 00 =		Mrs. Doris			fe				d Number or R Terrace					•
Baltimore, M semit. Peges 1 and 2 Sepertment of Heelth. Important: if item 27 i ony injury or other tre		20a. Method of Disposition 1 Burial 2 □ Cre	mation 3 🗆 F	Removal from State		lace of Disp emetery, cr	oosition (Namematory or ot	e of her place)	May	26,		oc. Location - 0	City or Tov	vn, State
Baltimo permit. Peges Depertment of Important: If is eny injury or once.		4 Donetion 5 21. Signature Fymeral			Lak		w Mem.				eton 1	Sykesv Funeral		, MD e, P.A.
m goesa	-	23a. Part1. Enter the dis	ease or comp	lications that causes	- 1401	9// 1	Secon	d Ave	enue SW	Glei	n Buri	nie, MI	210	61
Physician /Medical		shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	ito. List only o	ne cause on each li a	ne.	uence of):	Cordi	OM	y ope	thus the spiral states and the spiral states are states as the	atory arres	t,		Approximate Interval Between Onset and Death
Examiner	Examiner	Sequentially list condition if any, leading to immedi- cause. Enter Underlying Cause (Disease or injury	ns, ete	b. Avio Due to (or as	a consequ	VIW	lor	Hea	AB	loc			(lonths
68760, <pre>gphysicien and ss the burial-transit</pre>	edical Exar	that initiated events resulting in death) Last		Due to (or as	a consequ	rou():	NE	-						LMAMI
O. Box (the death certify the ettending ched for use expected for the ettending ched for the ettending the et		IF FEMALE: 23b. Was decedent pregi in the past 12 month 1 ☐ Yes 2 MNo 9 ☐ Unknown	Hall	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	□Ectopic pre	gnancy cify)				23d. Date Mont	ot deliver	/ Jay Year
dS, Puires that signed bid be deta	בֿב	Part II. Other significant	conditions cor	ntributing to death b	ut not resu	Iting in the	underlying ca	ıse given i	n Part I.	236			oute to the	cause of death?
Division of Vital Records, I or Attending Physician: The law requires to affect death. Director: After this certificate has been signed in by the funeral director, page 2 should be apprehilt fastion. To Re Completed by	noidi									248	. Was an	24b. W	ere autops	by findings available oletion of cause of
Vital Retirement The I	ן נ	25. Was case reterred to	medical								Yes 2	d? de	ath?	X No
of Vital Physician: this certifice ral director, F	ם	examiner? 1 Yes 25 No	_	lospital: 1 Inpatie	nt 2 🗆 E	ER/Outpatie	nt 3□ DOA	04	 Place of Dea Mursing H 			e 6 ∏Other	(Specify)	
Vision o Attending Pt of death. • ctor: After th by the funeral		27. Manner of Death 1. Natural 5 2 Accident	Pending investigation	28a. Date of Injui (Month, Day	ry	28b. Time (Injury		. Injury at Work?				injury occurred		
Division of To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After I completely filled in by the funeral Medical Certification.			Could not be determined	28e. Place of Injubulding, etc	ury - At hor c. (Specify)	me, farm, st	reet, factory,	office		28f. Loca City	ation (Stree or Town, S	et and Number State)	or Rural F	Route Number,
C the Hospital thin 24 hours a to the Funeral I mipletely filled		29a. Certifier 1 C (Check only 0 N	Certifying Phys fedical Examin	sician: To the best of ner: On the basis of and manner sta	Granmian	vledge, dea on and/or in	th occurred at	the time, on my opinion	date and place on, death occu	, and due rred at the	to the caus	e(s) and manr and place, an	ner as stat d due to th	ed. ne cause(s)
To with view of the control of the c	Ē	29b. Signature and title of	2 Jau	ûa			1) 00	3274	4	1	Date signed (22	2006
6		MAMA GA	' (L)' .	MD 3	301	23a) (Type,	Print) to	D	(G)	en B	VM	ely	0 8	2101,1
State Registrar		MAY 2 MAY 2	5 2006	32. Registra	r's Sidoeti	TLE TOS	Se de							

			For State Registrar	State of Maryla		artment o				ene ₂ 006	16518
	Physici	_	1. Decedent's Name (First, Middle, Last) H. Joan Kruh						2. Date of Death Month Mav	Day Year 21 2006	3. Time of Death 5:45 P M
7	/Medic Examin		4a. Facility Name (If not institution, give s 6311 Red Haven F			4b. City, Tov	wn, or Locati		1 -1)	4c. County of Death	
	Funeral Director		Social Security Number 6. Sex		7 Yrs.	If Under 1 Y		der 24 Hrs.	8. Date of Birth (Month, Day, Sept. 18	year) 3,1928 Nebra	place (State or Foreign
	Maryland f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Howard	10c. C	City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ∑No
	3a or 28a	I Director	10e. Street and Number 6311 Red Haven	Road		10f. Zip Co	21045		10	g. Citizen of What Cou	ntry?
36	be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "natural", or teme 23e or 28e-f ehow event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent f Yes, specify	Cuban, Mex	ican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
Baltimore, Maryland 21215-0036	within 72 house.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual O kind of work o DO NOT use r al Esta	fone during r etired)		ing 1	6b. Kind of Business/Ir Long & Fo	•
land 2	m = 0 5	To Be Co	17. Father's Name (First, Middle, Last) John Argabright	4	ı ke	ai ista	18. M		e (First, Middle, M		ster
, Mary	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked ery Injury or other traumatic e. <u>once.</u>		<u>`</u>	oand)	6311	Red Ha	aven R	oad (Columbia,	City or Town, State, Zij	21045
timore	t. Pages 1 nment of H rtant: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispo cemetery, crer etro Cr	matory or othe ematory	r place) Y	5/24	/2006	Oc. Location - City or T Catonsvill	e, Maryland
Ba	Dermi Depa Impo eny li		21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complic	ackma	~	5555 Tv	vin KN	olls I			yland 21045 Approximate
	Physician /Medical Examiner	nlner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, larry, leading to this editer. Sequentially list conditions, larry, leading to this editer.	e cause on each line. Dumb Due to (or as a conse	ntia equence of):	>					Interval Between Onset and Death
. 68760,	death certificate be executed is attending physician and yd for use as the buriat-transit.	Medical Examiner	resulting in death) Last	Due to (or as a conse							
.O. Box	the transfer of the transfer o	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 6 9 Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregr Other (special				23d. Date of delive	ery Day Year
α_	The faw requires that ite as been signed b page 2 should be deta	Completed by Ph	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	nderlying caus	se given in Pa	art I.	23e. Did toba	acco use contribute to to	he cause of death?
Division of Vital Records,										ed? death?	opsy findings available impletion of cause of 2 No
of Vit	Physicien: r this certific ral director,	To Be	TU Tes 21 NO		☐ ER/Outpatier		Other: 4		th Check only one one 5 Resider	ice 6 Other (Speci	fy)
sion	tending leath. tor: After the fune	Certification:	27. Manne of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	1	М	Injury at Work?	2□No	28d. Describe how	v injury occurred set and Number or Run	a l Pauta Alumbia
Dİ	or A fiter Sire in by		4 Homicide determined	28e. Place of Injury - At building, etc. (Special ician: To the best of my ki	cify)			and place	City or Town,	State)	
	To the Hospital within 24 hours e To the Funeral completely filled	Medical	(Check only 2 Medical Examir one)	ier: On the basis of examinand manner stated.	nation and/or in	vestigation, in	my opinion,	death occur	red at the time, da	te and place, and due t	o the cause(s)
)	S S S S S S S S S S S S S S S S S S S	-	29b. Signature and title of co difies	~~		I		77	7	d. Date signed (Month,	bay, rear)
	9		5450 KNOW	mpleted cause of death (It	00/110		1221	1045	- 3	ETER C	HEX
*	Sta Regist		31. Date filed (Month, Day, Year) MAY 2, 5, 2006	32 Registrar's Sig	S. And	ule					/

			For	State of Maryland			ntal Hygien	e	1 ~ ** 1 />
-3			State Registrar 1. Decedent's Name (First, Middentification)	idla Last)	Certificate of		Reg. No	2006	3. Time of Death
	Physicia		WALT	ER KING			Month ZO		Z47/R
A 影:	/Medic Examin		4a. Facility Name (If not institution	1 1	4b. City, Town,	or Location of Death	40	c. County of Death	
Arry .	Funcial	24.3	5. Social Security Number	6. Sex 7. Age (In yrs. la	ast birthday) If Under 1 Yea	r If Under 24 Hrs. 8	Date of Birth	9 Birthr	lace (State or Foreign
	Funeral Director	1	17-40-3925	5 × 2 F 62	Yrs. Months Days	Hours Min.	Wonth Day, Year	13 Ma	alland
land	Mo m		Usual Residence of Decedent 10a. State 10b. Count	ity 10c. City	, Town or Location	<u> </u>		1	0d. Inside City Limits
e Man	a-1 eh	ctor	MD	$\mathcal{B}_{\mathcal{A}}$	Utimor	e)			1 De es 2 □ No
with th	a or 26 the no	Funeral Director	10e. Street and Number	bara Ctra	10f. Zip Code	1207	10g. C	itizen of What Cour	ntry?
death	та 23	nera	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Decedent of	Hispanic Origin? (Speci ban, Mexican, Puerto Ri	fy Yes or No-	14. Race - Americ	
-0036 hours after death with the Maryland	r, or its	by Fu	1 Never Married 2 Ma 3 Widowed 4 Divorce	arried 1 ☐ Yes 2 No	1 Yes 2		can, etc./	Specify: 2	oc r
5-0036 72 hours at	ital Hygiene. Id other then "natural", or itema 23a or 28a-1 ehow event, the Madical Extraitmet must be notified at		15. Decede	ent's Education hest grade completed)	16a. Decedent's Usual Occu	upation e during most of working	16b. i	Kind of Business/Inc	dustry
within	then "	Completed	Elementary/Secondary (0-12)		life. DO NOT use retir	ed)	\mathcal{D}_{α}	40:10	Soloa
N B	intal Hygiene ed other the c event, Ine A	Be Co	17. Father's Name (First, Middle	e, Last)	Process	18. Mother's Name (First, Middle, Maide	n Sumame)	sures
aryland should be file	nd Menta marked imatic e	To E	Natter-	Jones		Ethe	LKI	79	
;, Mary and 2 shou	æ <u>=</u> ₩		19a. Informant's Name/Relation	Schip (Type, Print)	19b. Mailing Address (Stree	at and Number or Rural I	Route Number, City	or Town, State, Zip	21209
ore,	of Health fitem 27 r other tr		20a. Method of Disposition	n 3 □Removal from State	ace of Disposition (Name of metery, crematory or other pl	ace) Dar	20c. L	ocation - City or To	wn, State
altimore,			4 ☐Donation 5 ☐ Other ((Specify)	ngMeMorio	J Parks	126/06/	Bayto.	MD
	Pepa Impo eny ir		21. Signature of Funeral Service	ate MO1363	Varing h	ress of Faility Care	eye Fr	weral	Service
	ř.		23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that caused the death.	. Do not enter the mode of dy	ring, such as cardiac or	respiratory arrest,	LEVIN	Approximate Interval Between
2	nysician Medical		Immediate Cause (Final disease or condition resulting in death)	- Aspira	how the	2000011	1		Onset and Death
	xaminer			Due to (of as a consequ	ence of):				ι
P	sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):				
, xecute	and al-trans	Examiner	that initiated events resulting in death) Last	c	ence of):				
8760 ate be	physicien and the burial-transit	dical							
× 65	ettending ph I for use as th	/Med	IF FEMALE:	23c. If yes, outcome of pregnar	201				
. BOX 68/60, death certificate be executed	d for us	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic pregnan	су		23d. Date of delive Month	ny Day Year
F the Co	ed by the e	Phys	9 Unknown	9□ Unknown					
Records, P.O.	been signed i should be det		Rhad by	itions contributing to death but not resul かのしながら	Iting in the underlying cause g	iven in Part I.		use contribute to th	
VITAI RECOLDS, siclan: The law requires t	s beer 2 shou	Completed by	Azute &	enal HAILUA	le		24a. Was an	24b. Were auto	psy findings available
		Com	Penphera	e Vasclae DI	seast=		autopsy performed? 1 ☐ Yes 2 ☐ No	death?	npletion of cause of 2□ No
VITE siclan	certific	Be	25. Was case referred to medic examiner? 1 ☐ Yes	Hospital:	-00	26. Place of Death (
VISION Of VITA Attending Physician:	After this	n: To	27. Manner of Death	28a. Date of Injury	ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury	4 Li Nursing Home	e 5 ☐ Residence d. Describe how inju		")
DIVISION 1 or Attending	death. tor: After th the funeral	catic		stigation	M 1	Yes 2 □No	(1)	*******	
DIV PlorA	s after il Direct id in by	Certification:	4 Homicide deter	building, etc. (Specify)	me, farm, street, factory, office)	28	f. Location (Street a. City or Town, Stat	e)	l Houle Number,
] To the Hospital	within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical (29a. Certifier (Check only one)	ying Physician: To the best of my know al Examiner: On the basis of examinati	vledge, death occurred at the ion and/or investigation, in my	time, date and place, and opinion, death occurred	d due to the cause(s at the time, date an	and manner as st	ated. the cause(s)
To the	within To the comple	Med	29b. Signature and title of certif	and manner stated.		nse number	Α	ate signed (Month, l	Dey, Year)
) 	1		30 Name and address of the	on who completed cause of death (Item	23a) (Tune Print)	PAUL PL	190	my 20,	2006.
4			JOSEPH	COIM, MD		PAUL PL	ACE B	ATTIME	ef, no
	Sta Registr		31. Date fited (Month, Day, Yea MAY 2 5 2	ar) 32. Registrar's Signat	Special				
DHME	17 Rev 1/2	001	HILL TO LE	The state of the s	8				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year 6:05 P M Kanwal 2006 Jugesh Kaur May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F Yrs. Director 69 216-90-4662 Oct 29, 1936 Pakistan Usuel Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f ahow the Medical Examinar must be notified at 1 ☐ Yes 2 X No Maryland Montgomery Potomac Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10503 Rivers Bend Lane 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 4yr Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ss 1 end 2 should be fi of Health and Mental H I item 27 is marked of Sunder Singh Mohinder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mandeep Chhabra/nephew 1178 Gumbottom Road Crownsville, Maryland 21032 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If its any injury or ot once. 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 5/20/2006 Odenton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Momas Juanita (K) 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Subarachnoid Hemorrhage /Medical Due to (or as a consequence of): Examiner Aneurysm Sequentially list conditions, if any, leading to infinite cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as a sonsequence of). Examine ettending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): 68760. Physician/Medical Box (23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the e o. 9☐ Unknown 9 Unknown Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Š 3 ☐ Probably 4 ☐ Unknown Hypertension Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 📉 No 1 Yes 2√ No Vital To the Hospital or Attanding Physicien: within 24 hours effer death.
To the Funeral Diractor: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2√2 No 1 Inpatient 2 ER/Outpatient 3 DOA ð 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Ecritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Carthier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Column, M.D May 18, 2006 D36552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U P. Talwar, M.D. 50 W Edmonston Drive #401 Rockville, Maryland 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day May 23,2006 **Physician** 10:15 a Kyung Eun /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 🖫 F 1959 Korea May 12, Director N/A Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, It a Medical Exact it ar must be notified at 1 ☐ Yes 24 ☐ No Timonium Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Korea 21093 21 E. Timonium Rd. Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 25 Married Specify: Asian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "n any injury or other traumatic." College (1-4or 5+) Elementary/Secondary (0-12) Self-Employed Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Soon Youn Nag Gu Lee ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21 East Timonium Rd., Timonium, MD 21093 Kyung Baek- husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5/24/2006 Catonsville, MD Metro Crematory 21. Signature of Funeral San ce Licensee ^{22. Name and Address of Facility}
Gary L. Kaufman Funeral Home at MMP, INC.
7250 Washington Blvd., Elkridge, MD 21075 40123 23a. Part1. Enter the disease br complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Gastric Immediate Cause (Final cmur montins Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months?

1 Yes 2 No
9 Unknown Month ō 4☐Pregnant at time of death 5 Other (specify) detached Division of Vital Records, P.O. the 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has t lirector, page 2 s autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 other (Specify) 1 ☐ Yes 2 ☐ No P this Il Director: After this id in by the funeral o 28d. Describe how injury occulred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie cal (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 58303 MAY 23 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. CHARLES STREET Annion CHARLES, MO TOWSON MD ZIZOY 2. Registrar's Signature 31. Date filed (Month, Day, Year) . State Registrar MAY 2 5 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** JUNE b: 00pm LANGE MAY DUROTHY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3498 N. Chatham Road Ellicott City
If Under 1 Year | If Under 24 Hrs. Howard 8. Date of Birth (Month, Day, Year) March 27, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🖾 F Yrs. 1929 Maryland **Director** 215-28-7998 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "natural", or Items 23c or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Howard Ellicott City 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3498 N. Chatham Road 21043 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vernon A. Evans Dorothy Williams 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other trai 3498 N. Chatham Road; Ellicott City, MD 21043 Robert W. Lange Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/27/2006 * 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park Sykesville, Maryland 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licenses 23a. Part1. Enter the diseas or complications in the used the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) CORONARY DISEASE Onset and Death /Medical Due to (or as a consequence of):

Physician Examiner

Baltimore, Maryland 21215-0036

signed by has To the Hospital or Attanding Physician: To the Funeral Diractor: After this certific completely filled in by the funeral director. within 24 hours a To the Funaral C

Completed

Be

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Certification:

Medical

State Registrar

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

al Examiner	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
y Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23			
y Pt	Part II. Other significant condition	ns cont			

23c.	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □E0 5 □ C
ntrib	outing to death but not resulting in	the unde

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Due to (or as a consequence of):

Ectopic pregi Other (speci	

23d. Date of delivery Month Day

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			tribute to the cau	
	1 Yes	2 🗆 No	3 Probably	4 🔲 Unknown
42	Wasan	24h	Were autonsy fir	ndinos available

	24a. Was ar autopsy perform 1 Yes 2	/
26. Place of Death (6	Check only one	a)

prior to completion of cause of death?

1 Yes 2 No

Year

25. Was case referred to medical		
examiner? 1 🗌 Yes 2 🗷 No	Ho	spital:
27. Manger of Death		28a. C
Natural 5 Pending investigation		(-
2 ☐ Accident investigation	n	

5 Pending investigation	28a. Date of Injury (Month, Day Year)
6 Could not be	28a Place of Injuny . At I

2 🗆	ER/Outpatient	3□ DOA	Other:	4 🗌 Nursing	Home
ar)	28b. Time of Injury		Injury at Work?	2 □ No	280

/1110	3 2 1103	UOIIC	,a U		1.
28d.	escribe	how	injury	occurred	d

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00-	Onetition
234.	Certifier
	(Check only
	onal

3 Suicide

4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deat 1 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, an nvestigation, in my opinion, death occurred	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
29b. Signature and tille of certifier	29c. License number	29d. Date signed (Month, Day, Year)

29c.	Licer	se n	umbe	ər	
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29d. Date signed (Month, Day, Year)

MAY 24, 2006

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31. Date filed (Month, Day, Year) 5 2006



				For State	State of Ma	aryland / [ealth and M	lental Hy	/gier	Je () ()	6	6523
				Registrar 1. Decedent's Name (First, Middle, La.	oet)		Cer	tificate of E	Jeath	2. Date of D	Reg. I	No.		3. Time of Death
		Physicia	an	P	LIDKE					Month		Day LOO	ar /	1020AM
		/Medic Examin		4a. Facility Name (If got institution, giv				4b. City, Town, or	Location of Death	1417		4c. County of E		10201
		Examin	er	HARBITA MEMORIA	A HOGELT	W.		HAVro	de GRA	ap.		HA	Chr	d
		Funeral		5. Social Security Number 6. S		(In yrs. last bir	thday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth	9.	irthpl	ace (State or Foreign
		Director		220-52-6077	□ M 2X F	57	Yrs.	Months Days	Hours Min.	8. Date of B (Month, D March	11,	1949 N	lary	ace (State or Foreign N) Land
		put 🖈		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation					10	d. Inside City Limits
		Aarylis I sho	ō	Maryland Harford		Abero								1 □ Yes 2X No
		the h	Director	10e. Street and Number		71001	acci	10f. Zip Code		•	10g. (Citizen of What	Count	ry?
		3a or	Ö	128 West Aztec St	reet			210	001			USA		
		ms 2	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. W		spanic Origin? (Spe n, Mexican, Puerto	city Yes or N	0-	14. Race - A		
	ဖွ	after or Ite	Ē	1 ☐ Never Married 2 X Married	1 Yes 2 X	10		Tes, specify Cubar ☐ Yes 2 XNo	Specify:	nican, etc.)		Black, V	wnite, e Whi	
	933	urel'.	d by	3 Widowed 4 Divorced	Year or Dates:									
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	12	within ene. than	diu	Elementary/Secondary (0-12)	College (1-4or 5	+)		lomemaker				Own Ho	me	
	9	filed Hygi other ent. I		17. Father's Name (First, Middle, Last,)				18. Mother's Name	(First, Middle	e, Maid		1110	
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	ary	should be something simple with the simple win the simple with the simple with the simple with the simple with		19a. Informant's Name/Relationship (Туре, Print)	196	. Mailin	Address (Street a	nd Number or Rura	I Route Numi	ber, City	y or Town, Stai	e, Zip	Code)
0	Z	and 2 saith a n 27 i er tre		Lloyd Lidke, Hus	sband				Street		en,	Maryla	nd	21001
Ŏ	ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place o cemete	f Dispos ry, crem	ition (Name of atory or other place	p)	ate	20c.	Location - City	or To	vn, State
25	Ë	Pag ment ent:		`4 □Donation 5 □Other (Special	y)	Metro			nc. 05/2		Ba	altimor	e,	Maryland
	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or Items 23a or 28e-f show any injury or other treumatic event, It e Madical Examinar must be notified at once.		21. Signature of Funeral Service Lice Inomas Gregor	My-		22.	Name and Address remation	s of Facility Society cick_Road	Of Mar	ylaı	nd Inc.	100	A 21222
7		-		23a. Part1. Enter the disease, or com shock, or heart failure. List only		the death. Do	not ente	r the mode of dying	, such as cardiac o	r respiratory	arrest,	e, nary	Lan	Approximate Interval Between
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٤	100	sit od	iner	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	on:							
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	Вох	eath certif attending for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		2 🗆	Catania aragnasay				23d. Date of	deliver	у
	m	death	icia	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant at 9□Unknown			Ectopic pregnancy Other (specify)				Month		Day Year
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7	of Vital Records, P.O.	e law has b	Completed							24a. Wa	s an opsy ormed?	24b. Were prior	autop to com	sy findings available pletion of cause of
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G	Z.	sicier certif recto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 □ ER/Oı	-tati-nt	3 DOA Othe	26. Place of Death r: 4 □ Nursing Hor			0.000	2 16	
$\overline{\mathcal{X}}$	of	g Phy er this eral d		27. Manner of Death	28a. Date of Inju (Month, Da		Time of	28c. Injury	at 2	28d. Describe			эреспу,	
7	ion	nding ath. r: Afte e fund	atlo	1 Natural 5 Pending 2 Accident investigatio		(Year)	Injury	Work M 1 □ Y	? ′es 2 □ No					
	Division	r Atte	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injuding, etc	ury - At home, fa	arm, stre	et, factory, office		28f. Location City or To	(Street own, Sta	and Number or	Rural	Route Number,
		spitel or Attending Physicien: ours after death. ere! Director: After this certific filled in by the funeral director,												
		To the Hospitel or Attending Physicien: To the Final 24 hours after death To the Finaled Director: After this certifics completely filled in by the funeral director, p	edical	29a. Certifier (Check only one) 12 Certifying Pl 2 Medical Example (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination ar	e, death nd/or inv	occurred at the timestigation, in my op	e, date and place, a inion, death occurre	and due to the ed at the time	cause , date a	(s) and manne and place, and	r as sta due to	ited. the cause(s)
		To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	1 240			29c. License	number		29d. [Date signed (M	onth, D	lay, Year)
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		\		30. Name and address of person who	/	eath (Item 23a)	(Туре, Р	Print)	41/0 A.	Alm 1	6	Rhan .	40	
		Sta	to	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	uly	Wil Wh!	110 1/1	INACA	$y \cup y$	NE	9	
		Registr		MAY 2 5 2	006	we ship .	STATE OF THE PARTY	nge/						

Please Type or Print in Black Indelible Ink

Lynn Donald Lettley, Jr.

State of Maryland / Department of Health and Mental Hygiene

2006 | 6521

		1- For State Registrar			Cer	rtificat	te of L	Death				R	Reg. No.	Strong.	0 0		1 10 0 1
Physicia dical Examir	n/	1. Decedent's Name (First, Mid	dle,Last)	Do	nald			Lett				Date of Dea Month May 20, 2	ath Day	Year		3. Time o 1952	
		4a. Facility Name (if not institut Johns Hopkins Bayv		_				Baltimo		ocation of	Death		4c.	. County o	Death N A		
Funeral Director		5. Social Security Number	6. Sex	_	7. Age (In yrs. la			If Under Months		If Under:	24Hrs. Min.	8 Date of Bi	,	ĺ	9. Birth Foreign Cou		
	}	051-62-0498 Usual Residence of Decedent	1 M	2_ X F	28		Yrs.					08-	-22-	1977			N.Y.
nd ihow any ce.	١	10a. State 10b. Count	/		10c. City,	New									- 1		e City Limits
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 1315 Amste	rdam	Ave				10f. Zip C	ode 0027	7			10g. Citiz	zen of Wha	at Count	гу?	
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	eral	11. Marital Status				.S. 1		Decedent	of Hispa			cify Yes or No	0-	14. Race - White		an Indian	Black,
after der ral", or i	by Fun	3 Widowed 4 D	ivorced or D	ates:				res 2						Specify:		ack	
hin 72 hours after e. than "natural", tedical Examiner	ompleted	15. Decedent's Education (Sp Elementary/Secondary (0-12	-	ghest grad College (1		du	ring mos	st of work		n (Give kir 00 NOT us				(ind of Bus	iness/In	dustry	
5-0036 iled within 7 Hygiene I other than the Medical	Comp	12th grade 17. Father's Name (First, Midd	e, Last)				nkn		18	.Mother's	Name (F	irst, Middle,		Unkn Surname)			
2121	o Be	Lynn 19a. Informant's Name/Relation	nship (Type.	Print)	Foxwo		Mailing /	Address	(Street a	and Numb		ancine		ty or Town		ettle	-
nore, MD 21215-0036 ages I and 2 should be filed within 72 in of Health and Mental Hygiene I: If filem 27 is marked other than other transmatic event, the Medical		Francine Let			Mother		1315	A m	ster	dam	Ave	., Ne	w Y	ork,	Ne	w Yo	rk
Baltimore, MD 21215-003 pernit Pages I and 2 should be filed within Department of Health and Nental Hygiene Important: If iren 27 is marked other thinjury or other traumatic event, the Med		1 X Burial 2 Cremati	a. Method of Disposition X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Green Cem. 6-3-06 Morgan														
Baltin permit Departm Departm Importa		21. Signature of Funeral Service	e Licensee 22. Name and Address of Facility Baltimore,										, Mc	1. 2	L202		
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Examiner		Immediate Cause (Final disea or condition resulting in death)			nshot Woun												Death
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8760, inficate be executed ing physician and as the burial - transit	edical	UNPENDED		MENDED	· ·												
∞ ∃ ∃ ⊗	5	IF FEMALE: 23b. Was decedent pregnant in past 12 months?		Live b	ant at time of de	2	=	al death er (Specif	3 <u></u>	Ectopic p	oregnand	Э	230	Date of o	delivery Da	ау	Year
P.O. Box 68 sthat the death certificated by the attending detached for use a	by Phy	Part II. Other significant cond				esulting i	in t he un	derlying o	ause giv	en in Part	; I.		_	use contrib	_		_
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cian:	Be (25. Was case referred to medi examiner?	cal Hospi	ital:		1			10	f Death (C			1 -		1.70		
F K	오	1 Yes 2 No 27. Manner of Death		28a. Date	npatient 2		patient me of Inj		^	at Work?		Home 5 8d Describe	Reside		Other		
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ː돌 등 등 조.	Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide (Specify) Street Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street Subject was shot 28f. Location (Street and Number of Town, State) 1111 Dundalk Avenue, E												Number, City				
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To To Corr	Me	29b. Signature and title of cert		, mailiner s	7.0				License O.C.M					Date signe		h, Day, Y	ear)
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Regist			5 2006	1	Eleve .	K.	600	de									

Amend Item 23a per Dr., G855, 05/25/06dhb.

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 23:37 Robert Μ. Lucas May 13,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 XM 2 ☐ F 83 Director 142-12-3675 8/30/1922 NJ Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle r then "nature!", or items 23a or 28a-f ehovite Medical Examiner Tust be notified at MD Anne Arundel Odenton 1 Yes 2 No Director eet and Number 484 Holiday Street 10f, Zip Code 10g. Citizen of What Country? 21113 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No unk. If Yes, Give Year or Dates: Never Married 2☐ Married Maryland 21215-0036 1 ☐ Yes 2 XX Specify: Specify. white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 12 5+ Pages 1 and 2 should be filed vitnent of Health and Mental Hygis tant: If Item 27 is marked other jury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Paul D. Lucas Helen Raymond ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Lucas 4 Duck Cove Bridgeton, NJ 08302 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cregnation 3 Removal from State permit. Page Department of Important: If eny injury or once. Fernwood Memorial Park May 19, 2006 Hopewell Township 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Aspiration Pneumonia Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner eum if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death signed by the at be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 3 ☐ Probably 4 ☐ Unknown 1 Tyes page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 **X**No funeral director. Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No patient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Z Accident Injury To the Hospital or within 24 hours after death.
To the Funeral Director: After completely filled in by the fur 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00060824 13/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WASH MED CTR, GLEN BURNE MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIĞINAL

DHMH 17 Rev 1/2001

17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 15cm 16a per 17 8855 5-25-06 vt. For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death EWIS CINUA **Physician** /Medical 4b. City, Town, or Location of Death Name (If not institution, give street and number) 4c. County of Death Examiner Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6 Sex last birthday **Funeral** Months Days 1 □ M 2 ▼F Director Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits in then "naturel", or Items 23s or 28s-1 show the Medical Examiner must be notified at 1 Kes 2 No Director more 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes No Specify 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

ASSOCIATE 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry aty (0-12) College (1-4or 5+) Item 27 is marked other other treumatic event, I 18. Mother's Name (First, Middle, Maiden Sumame) Name (First, Middle, Last) 17. Father's Be and Mental ဦ Sister 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number orrane Depertment of H Important: if Iter eny injury or oth once. 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee lun W. 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) 9 MONTAL **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) ettending physicien a for use as the burial-Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by No 3 Probably 4 Unknown 1 Yes 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes After this certification funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Medical Certification; To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 □No 2 Accident investigation Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item) 0110 100 910 l 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 2

DHMH 17 Rev 1/2001

Registrar

5 2006

			1 - For State Registrar	State of Maryland		artment of H			iene	006	165	27
			Decedent's Name (First, Middle, Last)					2. Date of Deat	h	Vari	3. Time of	Death
	Physici		Bernardine W.	McPherson				Month May	23,	2006	1:30	A ^M
	/Medic Examin		4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, or	Location of Death		4c. Co	ounty of Death		
			365 Friar Trai	.1		Annar	oolis		A	nne Aru	ındel	
Т	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or	Foreign
	Director		243-74-2477	M 21∑F (50 Yrs.			June 16	, 19		th Car	<u>olina</u>
	pu s		Usual Residence of Decedent 10a, State 10b, County	10c. City.	Town or Lo	cation					Od. Inside Cit	v Limits
	eho eho	'n									1 🗌 Yes	
	28a-1	Director	Maryland Anne Aru	niger	All	napolis		1	Og Citize	n of What Cour		
	with o					2140	1		-		,	
	ns 23	Funeral	365 Friar Trail 11. Marital Status 12	. Was Decedent Ever in U.S	S. 13. V		L ispanic Origin? (Sp	ecify Yes or No-		USA . Race - Americ	can Indian,	
_	fer d	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X	1	f Yes, specify Cuba	ın, Mexican, Puerto	Rican, etc.)		Black, White,		
3	urs a	by	3 ☐ Widowed 4√ Divorced	If Yes, Give 25 Year or Dates:		I∐Yes 2)X No	Specify:		S	pecify: Whi	.te	
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7	filed withi Hygiene. other then	ည် မ		5+	Tea	cher				ic Scho	ol Sys	tem_
פ	2 2 2 2	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Su	imame)		
<u> </u>	should be nd Mental marked c	ျ	Henry Clay McPhers				Dolly				- 10	
<u>a</u>	ie m	1	19a. Informant's Name/Relationship (Type		1		and Number or Run		200.000	SERVELINE	Code)	
Baltimore, Maryland 21	as 1 and 2 should bot Health and Ment Item 27 ie marked rother treumatic e		Henry C. McPherson 20a. Method of Disposition	, Brother	445/ F	redericksu	ing Circle i	ate	AL 20c Loca	35213 tion - City or To	own State	
Ö	Pages nent of H int: If Ite		1 ☐ Burial 2 🎇 Cremation 3 ☐ Rei	moval from State	metery, cren	natory or other plac	:e)					
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g	permit. Departr Importa eny inju		21. Signature of Funeral Service Line see	4-	22	Cremation	ss of Facility n Society erick Road	Of Mary	land	Inc.		20
			Thomas Gregor 23a. Part 1. Enter the disease, or complication	ations that caused the death						Maryla	Approximate	
. =		2 10	shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	0			or respiratory arri			Interval Betw Onset and D	veen leath
Е	Physician /Medical		disease or condition resulting in death)	CANCER	07	NEASI					5/2	YEAN
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É	uted d ansit	Examiner	Cause (Disease or injury that initiated events c.									
7	sicien and burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):							
8760,	death certificate be execute ⁶ d e attending physicien and of for use as the burial-transit	dical	d.									
9	death certific attending pl		IF FEMALE:									
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy			230	 d. Date of delive Month 	•	ear
O	at the de by the a tached f	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	ath 5∟	Other (specify)						
ď	The law requires that the tite has been signed by the bage 2 should be detache		Part II. Other significant conditions conti	ributing to death but not resu	Iting in the u	nderlying cause give	en in Part I.	23e. Did tot	acco use	contribute to t	he cause of de	ath?
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g		ပိ	25. Was case referred to medical				26. Place of Deat	1 Yes 2	-	1 🗆 Yes	2∐ No	
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ō	g Phy ter thi		27. Manner of Death		28b. Time of		v at	28d. Describe ho			,,	
0	ttending I death. stor: After / the funer	atle	1, 2 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monar, Day 18at)	Injury		Yes 2 □No					4
Division of Vital Records,	or Attendation detector: in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (St City or Town		Vumber or Rura	A Route Numb	er,
ā	itel or A rs after et Direction	Cer										
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director:	cal	(Check only 2 Medical Examine	cian: To the best of my know er: On the basis of examinati	vledge, deatl	n occurred at the tin	ne, date and place, pinion, death occur	and due to the cared at the time, do	ause(s) ar ate and pl	nd manner as s lace, and due t	tated. the cause(s)	
	To the H within 24 To the Fi complete	Medical	one)	and manner stated.		29c. Licensi			<u> </u>			
	7 × 5 × 5	-	29b. Signature and title of certifier	1.1/2 ~	m		/			signed (Month,		
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	10		30. Name and address of person who com	1001 m 9	23a) (Type,	FINI)	8/18 = 00 Mi	NOMANUL	15	m >	1401	
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State of Maryland / Department of Health and Mental Hygiene 2000

			1 - For State Registrar	Olaro ov many tame v o	Certificate of	Death	Reg.		10020
	Physici /Medio			cNutt	:			Day 2006	3. Time of Death
	Examir	er	4a. Facility Name (If not institution, give Baltimuse Waching	ton Medical Center	Glen B			Anne Aru	
	Funeral Director		220-20-0447	757	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye March 4,	1928 Mar	place (State or Foreign intry) y Land
	yland now		Usuat Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Ba-fel	ctor	Maryland Anne Aru	ındel Pa	asadena				1 ☐ Yes 2 XNo
	with th	Dire	10e. Street and Number		10f. Zip Code		10g.	. Citizen of What Cou	ntry?
	ne 23	Funeral Director	210 Kenwood Road	12. Was Decedent Ever in U.S.	21122	ispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Ameri	
Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or iteme 23s or 28s-f ehow other traumatic event, the Mudical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 ሺ No If Yes, Give Year or Dates:	If Yes, specify Cuba	nn, Mexican, Puerto	Rican, etc.)	Specify: White	
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pu	uld be filed fental Hygic rked other tic event, II	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, Mai	den Sumame)	
3	2 should be and Mental is marked sumatic ev	은	Unk. 19a. Informant's Name/Relationship (7)	roe Print) 19h	Mailing Address (Street	-	e Baker	ity or Town State 7	in Code)
Ma	1 and 2 s Health ar tem 27 is		Larry McNutt, So) Kenwood Ro				
ore,	of He of He if item or othe		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ F	20b. Place of	Disposition (Name of crematory or other place			c. Location - City or T	
ţ	t. Pag rtment rtant: njury o		4 □ Donation 5 □ Other (Specify)	Metro (Crematory In			altimore,	
Bal	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		21. Signature of Funeral Service U.S. Thomas Gregor	ign	Cremation 299 Freder	Society cick Road	Of Maryla Baltimor	nd Inc. e, Marylan	nd 21228
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the death. Do no					Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	asystole					Onset and Peath
	Examiner			Due to (or as a consequence o					2 dans
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of	f):				Cla
45	ecute and I-trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence o					5 days
68760,	certificate be executed ording physician and use as the burial-transit	Medical E			thrombos	, n			2 days S days S days
Box 6	in gra		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy				23d. Date of deliv	ery
o.	w requires that the death ce been signed by the attend should be detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetaf death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
S, D	The law requires that the site has been signed by the bage 2 should be detached.		Part II. Other significant conditions con	ntributing to death but not resulting in	the underlying cause give	en in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
of Vital Record	requir	Completed by	regardice				1 🗆 Yes	2 Prol	babły 4 ∏Unknown
Rec	e la has	mple					24a. Was an autopsy performed	prior to co	opsy findings available empletion of cause of
ta		Be Co	25. Was case referred to medical			26 Place of Deat	1 ☐ Yes 2 🗷		2□ No
Ž	S 20 5	To B	ayaminar?	lospitaf: 1 Inpatient 2 ☐ ER/Out	patient 3 DOA Othe			e 6 □Other (Specia	(5y)
o n	ling Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Ti	ury Work		28d. Describe how i	njury occurred	
Division	Attending ir death. ector: Atter by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Ptace of Injury - At home, farr		Yes 2 □No	28f. Location (Stree	t and Number or Rura	al Route Number.
Ö	rs after ai Dire	Cert	4 Homicide	building, etc. (Specify)			City or Town, S	ate)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowledge, her: On the basis of examination and and manner stated.	death occurred at the tim for investigation, in my op	ne, date and place, pinion, death occur	and due to the cause ed at the time, date	e(s) and manner as s and place, and due t	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1	29c. License	_	2.4	Date signed (Month,	
			Strint	Hours to	000	22483	in/	cry az, a	COC
	3		30. Name and address of person who	chs mp 305	ype, Print)		on Burni	o mn	21061
7 8	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1003 101/00	1012 00	(1J011U	() 110 6	7(-0)
	Registr	ar	MAY 2 5 20	06 Blans &	Goerfes .				
DH	MH 17 Rev 1/2	001			*				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MON McLeaurin **Physician** D Aggie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltons Balton De med enter Bayview If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2 🗓 F Director 05-28-1933 M 239-64-0443 Usual Residence of Decedent Manyland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show r items 23s or 28s-f shov inger nast be notified at 1 Yes 2 □ No Director Md. NA Baltimore the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with (21213 1240 N. Ellwood Avenue IIS A death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Amied rollos 1 ☐ Yes 2 ☐XNo Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify Yes, Give If Yes, Give Year or Dates: Black þ 3X Widowed 4 ☐ Divorced "natural". or than "natura" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Nursing Key Circle Hospice Asst. 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Health and Mental Smith Roland Annie Cobbs ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5706 Anthony Avenue, Baltimore, Md. : If item 27 i Stephanie Smith Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 Nurial 2 □ Cremation 3 □ Removal from State 4 □ Dopation 5 □ Other (Specify) 5-27-06 Md. Baltimore, Garden of Faith 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metustatic loyeun **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy for Month Day Year in the past 12 months? 5 Other (specify) □Yes 2□No be detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 27 No 1 Yes Attending Physicien: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred filled in by the funeral 28c. Injury at Work? After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 0 Hospital 24 hours a 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical within 24 ho To the Func 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Tothe 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Sgistrar's Signature

and address of erson who completed cause of de estem 23a) (Type, Print)

5 2006

Physicia	an	Decedent's Name (First, Middle, La JESSIE				MALL				2. Date of Dea		606	Year	3. Time o	
/Medic Examin	- 6	4a. Facility Name (If not institution, gi						Location o			_		of Death	BALTI	
Funeral Director		Social Security Number 6.		Age (In yrs. la		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt 04/17/2			9. Birth Cou	place (State ontry)	or Foreign MD
ahow dat	_	Usual Residence of Decedent 10a. State 10b. County	TMODE	10c. City	, Town or Lo									10d. Inside C	ity Limits
rms 23a or 28a-f ehow rights be notified at	Funeral Director	MD BALT	IMORE		BALTI	10f. Zip					10g. Cit	izen of	What Cou		- 74
ms 23a c	eralD	3800 OLD COURT	ROAD	ent Ever in U.S	S. 13.1	Was Deced		21208		ecfy Yes or No	.	14. Rac	e - Ameri	USA can Indian,	
ural', or item	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	s? XINo		fYes, spec 1 ☐ Yes 2		n, Mexican Specify:	i, Puèrto	pecify Yes or No- o Rican, etc.) 14. Race - Black, Specify:			ck, White,		
i Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a o other traumatic event, Ire Madical Extrainer must be	Completed by	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	Education rade completed) College (1-40	or 5+)	16a. Dece (Give life. TEAC	kind of wor DO NOT us	I Occupa k done d se retired	ation during most	t of work	ing			usiness/Ir	dustry	
nd Mental Hy marked other matic event,	To Be C	17. Father's Name (First, Middle, Las I SAAC	t)		JUDMA	N			Pr's Name	e (First, Middle,	Maiden	Suman	,	LENKOV	l
alth and I		19a. Informant's Name/Relationship AARON MALL / SON				-				al Route Numbe BALTIMOI					2
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Departn Importe any infu		21. Signature of Funeral Service Lice	attle							LEVINS					208
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by the attending physician tached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2₽□ No 9 □ Unknown		n 2 ☐ Fetal tat time of de	death 3[Ectopic production of the contract of the cont							ite of deliv		Year
been signed by the attending ph should be detached for use as th	Ď	Part II. Other significant conditions	contributing to deat	h but not resu	ulting in the u	nderlying ca	ause give	en in Part I	•					he cause of	_
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t hours uneral	ledical Ce	(Check only 2 Medical Ext	Physician: To the beaminer: On the basi	s of examinat	wledge, deat	h occurred vestigation,	at the tim	ne, date an pinion, dea	nd place, th occur	and due to the	cause(s)	and made,	anner as s	stated. o the cause(s)
within 2.	Med	29b. Signature and title of certifier	and manner	r stated.		290	. License	e number			29d. Da	te signe	ed (Month,	Day, Year)	
		30. Name and address of person who	Hegm	e doct "	2201 77 -	Berga'	523	450			5	16	106		
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C+a	te	31. Date filed (Month, Day, Year)	32. Heg	istrar's Signa	Area										

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrer		State of Ma	ırylanı			t of Hea e of De			Reg. No.	2006	1653		
	ysicia		Decedent's Nam	e (First, Middle, Last	∍ Joseph E	dwai	d Mor	gan,	Sr.		2. Date of De	Day 21	Year 720	3. Time of Death		
	Medic kamin		4a Facility Name ((not institution, give		sita	1		Town, or Lo	cation of Death	1.114		BaH	in		
	neral ector		5. Social Security N 058-14	-0586	x 7. Age ⊒XA 2 ☐ F	(In yrs. 1	ast birthday) Yrs.	II Unde Months		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Nov	th ay, Year) 4, 1915	9. Bir	thplace (State or Foreign ountry) Maryland		
yland	ם		Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits	_	
he Mar	ciffed	Director	Maryland		imore			1.04 =		le River		12 000		1 TYes 2 No		
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2 hours	ical Ex		3 Widowed	15. Decedent's Edu	ucation	·	16a. Deced	dent's Usu	al Occupatio	n na mest of wor	tion		d of Business		_	
within 7	Die Mod	Completed	Elementary/Seco		College (1-4or 5	+)	life. L	DO NOT i	se retired)	ng most of wor	king		U. S. G	overnment		
al Hygid	vent, I	Be Co	17. Father's Name	(First, Middle, Last)	0.14						ne (First, Middle				-	
2 should be and Mental	matic	٦	Charles S. Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Name (Name) (Nam											Zio Code)	_	
and 2 sealth ar	er treu		Valerie Jo	nes Daughter			1	318 R	man Ric		elair, Maryl	and 21	014			
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Jing Phy Affer thi	funeral director, page		27. Magner of Dea 1 Natural	5 Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	f M	28c. Injury at Work?		28d. Describe	-		,	_	
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. 1			30. Name and add	ress of person who o	completed cause of d	eath (Item	23a) (Type.	Print)		74428		5	1221	04	_	
1	<i>Y</i>		Dr. Mi	chael P	ipkin 90	(V)	ran	Klin.	guar	e Dri	Ve B	alto.	MD	21237		
R	Sta egistr		31. Date filed (Mor	MAY 2. 5	32. Registra	ars Signa	ure.	peak	P				-			

		•	For State Registrar	State of	Marylan		rtment of tificate of				jiene eg. No. 2 (006	16532	
	D		1. Decedent's Name (First, Middle, Las		-				2.	Date of Dea	th Day	Year	3. Time of Death	
	Physici: /Medic		Rachel Ann	Peach M	lanner					VAY	24,2	2006	2:05 PM	
	Examin	_	4a. Facility Name (If not institution, give		oer)		4b. City, Town			•	4c. County of Death			
			Carroll Hospital 5. Social Security Number 6. S		Age (In yrs.	(act histogram)	Wes If Under 1 Year	tminst		Date of Right		rroll		
	Funeral Director			DM 600 F	77	Yrs.	Months Day		Min. No	Date of Birth (Month, Day V . 14	1928	g. Gar	place (State or Foreign ntry)	
		ŀ	Usuef Residence of Decedent						1 1					
	how	,	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits	
	Be-1 e	Director	MD Carrol	.1	F	inksbu							1 ☐ Yes 2 No	
	vith th	Die	10e. Street and Number				10f. Zip Code			1	0g. Citizen of		ntry?	
	s 23s	ara .	3414 Edolin Far	ms Court		S 113 1	Vas Decedent o	048	rigin? (Specif	y Ves or No-	USA 14 Ba	ce - Ameri	can Indian	
_	item item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Force	es?	.5.	Yes, specify Co	iban, Mexica	in, Puerto Ric	an, etc.)	Bfa	ack, White,	etc.	
200	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date		1	☐Yes 2XIN	o Specify	<i>r</i> :		Speci	_{fy:} Whi	te	
Š A	be filed within 72 hours after deeth with the Maryland tal Hyglene. d other than "natural", or Items 23a or 28e-f ehow event, the Madical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced	lent's Usual Occ kind of work don	upation	st of working		16b. Kind of 8	Business/In	dustry	
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Maryland 21215-0036	0 7 5	Be C	Frank W. P							nma McI				
2	should Ind Men	ဥ	19a. Informant's Name/Relationship (19b. Mailin	g Address (Stre					ı, State, Zip	Code)	
	end 2 ealth a m 27 io		Mr. Edmund J. Man	ner (Spo	use)	3414	Edolin	Farms	Ct., F	Tinksbu	irg, MD	2104	18	
Š.	of Hei		20a. Method of Disposition	D	1	Place of Dispo	sition (Name of natory or other p	lace)	Date	9	20c. Location	- City or To	own, State	
Ĕ	Peges nent of ant: If it ury or o		1 ∑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other <i>(Specif</i>		Cre	estlawn	Mem. G	ardens	5/27/	2006	Marric	ttsvi	11e, MD	
Baltimore,	permit. Peges 1 end 2 should b Department of Health and Menta Important: If Item 27 Ie marked eny Injury or other treumatic e <u>pnce</u> .		21. Signature of Funeral Service Licer	wit -		22 H	ATGHT F ykesvi1	UNERAL 1e. MD	HOME	& CHAP	PEL (Bo	x 195 400	5)	
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Box	leath certifica attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. ff yes, outco	me of pregna		Ectopic pregnar	псу				ate of delive	ery Day Year	
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٠.	het the	Phy	Part II. Other significant conditions of	contributing to dea	th but not res	ulting in the ur	nderlying cause	given in Part	L	23e. Did to	bacco use cor	ntribute to t	he cause of death?	
Vital Records,	requires thet the leen signed by th hould be detache	d by	•	•			, , ,				s 2 No		oably 4 Unknown	
င္ပဲ		ete								24a. Was a	n 24h	Were auto	nosy findings available	
Ř	nysician: The law r nis certificate has be i director, page 2 sh	Completed								autops perform	med?	death?	opsy findings available impletion of cause of	
ta	an: T tificat tor. pa	0	25. Was case referred to medical					26. Plac	e of Death (C	1 ☐ Yes	2 No	1 🗆 Yes	2 No	
	ysici lis cer direc	To B	examiner?	Hospital:	batient 2 🗆	ER/Outpatien	t 3 DOA	Other: 4 N	lursing Home	5 ☐ Reside	ence 6 □Ot	her (Specil	(y)	
0	Attending Physician: r death. ector: After this certific. by the funeral director.		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. In W	jury at ork?	280	d. Describe h	ow injury occu	rred		
Sio	r Attendi er death. rector: A by the fu	cati	2 Accident investigation 3 Suicide 6 Could not b					☐Yes 2☐		1				
_	- 9	Certification:	4 Homicide determined	288. Place 0	g, etc. <i>(Specit</i>	ome, tarm, str y)	eet, factory, offic	e e	281	City or Town		per or Hura	al Route Number,	
	To the Hoepital or within 24 hours after to the Funeral Discompletely filled in		29a. Certifier Certifying Ph	ysician: To the b	est of my kno	wledge, death	occurred at the	time, date a	nd place, and	due to the c	ause(s) and m	anner as s	tated.	
	n 24 ł n 24 ł ne Fui	Medicai	(Check only 2 Medical Examone)	niner: On the bas and manne	is of examina	tion and/or in	estigation, in m	y opinion, de	ath occurred	at the time, d	ate and place	, and due to	o the cause(s)	
	To th Withir To th comp	M	29b. Signature and title of certifier		~	4		nse number		2	9d. Date sign	ed (Month,	Day, Year)	
)	/		1 Mahan	C-14	/		200	575	52	N	1A-Y 2	4, 2	2006	
	5		30. Name and address of person who COULDSTAN MKAR 31. Date filled (Month Day, Year)	completed cause	of death (Iter	п 23а) (Туре,	Print)		0				A - 1/4	
			31. Date filed (Month, Day, Year)	C. MAG	ONAN	1001	4 rack	t R	U WE	S/Mm	SIER	MD	21157	
	Sta Registi		MAY 2 5 20	06 /20	sas A	ature	de							
				A COUNTY OF A SHALL		0 1								

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Mc Colgan **Physician** 11:45AM Lucile 2006 /Medical 4b. City, Yown, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Lutheran Village Carroll Westminster | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | Sept 10, 1917 9. Birthplace (State or Foreign Country)

LOWA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 210 F 88 Yrs. Director 384-20-0796 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b County or 28a-f show traumatic event, the Madical Examinar must be nutified at 1 ☐ Yes 2 ☐ No MD Carroll Westminster Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 St. Mark Way 21158 USA 238 Pages 1 and 2 should be filed within 72 hours after death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I L. Paul Goeser Emma Groethe 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Mr. Stanley P. McColgan (Spouse) 205 St. Mark Way #306 Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Laek View Mem. Park 5/31/2006 Sykesville, MD 21. Signature of Funeral Service Licensee 2HATGHT AGUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 tu 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ulumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Parkinsons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other. 4 Jursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Tes His 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 29c. License number DIETE tem 23a) (Type, Print) ress Way #11+ Eldesburg Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 5 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#16a-b, perFH, 885 at 37/Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** NEUBECK MAY 24, 2006 2:15 A. CHARLES /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FOREST HILL FOREST HILL HEALTH & REHAB CENTER HARFORD 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 19M 2□F Months Days Hours Min. 216-01-7680 Director MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No llStor Funeral Director 10e. Street and Number 10g. Citizen of What Country? 2104' a COVO 12. Was Decedent Ever Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status n U.S. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: δ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farming and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farmer 12 other traumatic event, permit. Pages 1 and 2 should be fite Department of Health and Mental Hy important: if Item 27 is marked other any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140(altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Yown, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) remorial Carden 21. Signature of Funeral Service Licensee 1311 MO 21050 22. Name and Address of Facility clest Simberl nother Enns tuneral 23a. Part1. Enter the diseast, or complete that cause if the death. Do not enter the mode of dying, such as cardiact shock, or heart failure. List only of cause on each line. Approximate Interval Between Onset and Death respiratory arrest. Immediate Cause (Final disease or condition resulting in death) **Physician** ongestive /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, I saving to limit solute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE: 950 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 □₩0 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? page this certificate 2 1 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Jursing Home 5 Residence 1 🗌 Yes 2 1 No Certification: To 6 ☐ Other (Specify) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 | Homicide Hospitai 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of Leath (Item 23a) (Type, Print) LAW STREET 8 DR. MANUEL LAZATIN ABERDEEN, MD. 21001 32; Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. state of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1331 Elton 05 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner VA MediCAL CENTER BALTIMORE LtimoRe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year, 5. Social Security Number
242-84-5318
Usual Residence of Decedent Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 10 M 2□F Yrs. Director filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or itema 23s or 28s-f show any injury or other traumatic event, it a Medical Examinar must be notified at once. Yes 2□No MI Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1004 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ★ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance 12+h 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship ype, Ph. 1) 10 Gibbor ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore LOLOY W. Morth aux Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1-Burial 2 Cremation 3 Removal from State Garrison Jorest Cemetery 5/30/06 Owings/ 22 Name and Address of Facility Voughn C. Greene Funeral service 8728 Liberty Rd Randallstown, MD 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Aspiration **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed sete has been signed by the ettending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificete has autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes efter death.

Director: After this certified in by the funeral director. 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Mnpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours el To the Funeral D completely filled i Hospital 29a. Certifier Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ş 29b. Signate title q P19685 XMD es of pers completed cause of death (Item 23a) (Type, Print) 30. Name and ad who 10NGREENE STREET BALTIMORE 3. Registrar's Signature 31. Date fled (Month, Day, Year) State 2 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygien Certificate of Death 2 Date of Death 1 Decedent's Name (First, Middle, Last) May 18, 2006 8:20 p " Physician Mary A. Peterson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Linthicum Chesapeake Hospice House Date of Birth (Month, Day, Year) Jun 14, 1935 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M X F No. Carolina Yrs 411-54-6820 70 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County r 28a-f show Yes 2 No Laurel Maryland Prince George Directo the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r then "naturel", or items 23s or the Medical Examiner must be a USA 20723 9793 Mountain Laurel Way - Apt 3d Funerai filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 Specify: à 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Factory College (1-4or 5+) Elementary/Secondary (0-12) **Factory Worker** 12 othert 18 Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked otherny injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) Janie Crawford Charles Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9793 Mountain Laurel Way - Apt 3D Laurel, Maryland 20723 Tisha Peterson Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Catonsville, Maryland 05/22/06 Metro Crematory, Inc. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility

Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BLADDER CANCER Physician METASTATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-fransit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 100
9 Unknown Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Records. HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 Yes 2 No Division of Vital the tuneral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence Dother (Specify) hospice 1 ☐ Yes 2 ☐ 16 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After Natural 5 Pending after death. 1 □ Yes 2 □ No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral L filled Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated. 29a. Certifier Medical completely To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Muy D0058290 5/22/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 QUEENSBORY RD. HYATTSVILLE, MD 20781 SURCESHKUWAR HITATITUM 32. Redistrar's Signature, 31. Date filed (Month, Day, Year) State 5 2008

Registrar

				State of Maryland /				_	17507
			For Stata Registrar	otato ot marytame,	Certificate of		Rag. I	2000	1003/
	Physici	an	Decedent's Name (First, Middle, Last)	Dall area	`		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	cal	Geral dine L 4a. Fecility Name (If not institution, give s			, or Location of Death	May	22 2004 4c. County of Death	
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	Funeral Director		5. Social Security Number	IN ONE	rthday) If Under 1 Yea Months Day	r If Under 24 Hrs. s Hours Min.	8. Date of Birth (Month, Day, Ye.	9. Birth Coi	nplace (State or Foreign untry)
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ne	the Maryland 28a-t ehow notified at	tor	10a. State 10b. County		on or Location Itimore				10d. Inside City Limits 1 Yes 2 No
dol	the	Funeral Director	10e. Street and Number 4320 Clareway	Apt. 4L	10f. Zip Code	21213	10g. (Citizen of What Cou	untry?
eralc		inera		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of	f Hispanic Origin? (Spe uban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
036	8 0 8	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 N	o Specify:		Specify: 3	lack
5-0	72 hours "natural" rdical Ex	eted	15. Decedent's Educ (Specify only highest grade	cation 16a completed)	a. Decedent's Usual Occ (Give kind of work don	e during most of worki	16b.	. Kind of Business/l	ndustry
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Baltimore,			20a. Method of Disposition 1 Scalarial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	20b. Place	of Disposition (Name of ary, crematory or other p	lace)		Location - City or 1	
3alti	permit. Peges Department of Importent: If i eny Injury or ance.		21. Signature of Funeral Service License	90		ress of Facility Coverne Full Road Batt	neval serv	lices	
	707 • d		23a. Part1. Enter the disease, or tomplic shock, or heart failure. List only on	Mol363	not enter the mode of d	L ROAD BAH ving, such as cardiac o	r respiratory arrest.	2	Approximate
	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	ne cause on each line.	un condia	l in Ener	tian		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	yof):	rijars	24011		130093
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Box	eath certific attending pl	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death		псу		23d. Date of delin	very Day Year
0	tt the de by the a tached f	Physician/Medi	1 Yes 2 No 9 Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)				
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	o the	Medical	one) 29b. Signature and title of certifier	and manner stated.		nse number		Date signed (Month	
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,	4		30. Name and address of person who co	No + 1		Sinai L	nospital	of Ba	2,2006 Itimore
18		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	w.	7 7 7 7	3-17-17		
-6	Regist	rar	MAY 2 5 2006	Beech Do As	Bell D				

YOUSEL, MARION imore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, <

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician PROUSER** MARION May 22, 2006 12:31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth 5. Social Security Number **Funeral** Min Months 0372071923 1 ☐ M 2 🙀 F Hours 83 MD 217-16-4974 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show or other traumatic event, it a Madical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21209 USA 3317 KATEWOOD COURT or items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Never Married 2 🕅 Married WHITE 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY FINANCIAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental is marked c SUGAR FOLAND SARAH WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any njury or other traignes. 3317 KATEWOOD COURT - BALTIMORE, MD 21209 BERNARD PROUSER / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD VETERANS CEMETERY 05/24/2006 5 ☐ Other (Specify) OWINGS MILLS, MD 4 Donation of Pineral Service Liced see 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Sign xur 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Requentially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or a a consequence of) Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Day Year 5 Other (specify) page 2 should be detached 9☐Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 20 Medicai Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 R/Outpatient 1 Inpatient 3□ DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person 0 Towser 15 21204 ハム SOME 11/1,000 31. Date filed (Month, Day, 32. Rigistrar's Signature State Registrar

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	To the P within 24 To the F complete	Medical		and manner stated.					
	P X P S	-	29b. Signature and title of certifier			29c. License number		ate signed (Month, Day,	
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7)		30. Name and address of person who con	inpleted cause of death (Iter	Car	enc.		ay 23,	AUG HVE
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Reiter Larl 23 70 0212AM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manyland University of Baltimur If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 13, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)

E **Funeral** 1**⊘**M 2□F 175-28-0378 71 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: if tem 27 Ia marked other than "natural", or itama 23a or 28a-f ahow any injury or other traumatic avent, the Medical Exerciser must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Howard Elkridge Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5915 Abrianna Way Apt. N 21075 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married X Widowed 4 Divorced 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Be Completed by Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Survey Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Reiter Mary Leighty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. MaryJean Reiter (Spouse) 5915 Abrianna Way Apt. N Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crestlawn Mem. Gardens 5/26/2006 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility HOME & CHAPEL PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** ntacrama Hemorhage nous /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ned by the attending physicien and detached for use as the human To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate hes autopsy performed? Be 25. Was case referred to medical 26. Place of Death | Check only one examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 in S After this funeral of Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Diractor: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) P17634 05 23 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 Sochen Green. tael Goldfedic Baltonine MD 21201 Street 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 2 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

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	Dhuaisi		1. Decedent's Name (First, Middle,						2	2. Date of De		/a a a . `	Year	3. Time of 3:56	Death D
	Physici /Medic		Ernesto		Rivas					May 1				J.J0	I M
)	Examin	er .d:	4a. Facility Name (If not institution, 2517 Breakwate	er Court				ldorf				County of Char 1	les		
ŵ.	Funeral Director		577 76 6848	G., -G.	i (In yrs. last b	Yrs.	If Under 1 Ye Months Day		Min.	Jan 6,	y Year) 192	5	9. Birthpli Y Count PUA	ace (State of	A A
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation						10	d. Inside Cit	ty Limits
	Mary Feeth	ţō	Maryland Charle	es			Waldor	f						1 🗌 Yes	2 No
	or 28g	Director	10e. Street and Number				10f. Zip Cod	9		10g. Citizen of What Country?			ry?		
	ath wi	rai	2517 Breal	kwater Court				0601				ted S			
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 Is marked other than "naturel", or Items 23a or 28s-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie XX Widowed 4 Divorced	12. Was Decedent I Armed Forces? d 1 □ Yes 2 □ 1 If Yes, Give A X Year or Dates:		-	Was Decedent of Yes, specify C			ify Yes or No ican, etc.)		14. Race Black, Specify:	- America White, e		
5-0	72 ho	eted	15. Decedent's (Specify only highest	s Education grade completed)	16	a. Dece	dent's Usual Oc	cupation	st of working	7	16b. Ki	ind of Bus	iness/Ind	ustry	
121	vithin ne. hen "	Completed	Elementary/Secondary (0-12)	College (1-4or 5			kind of work do DO NOT use rel	ired)			M	<i>C</i> -			
2	Hygie Hygie ther t		3rd 17. Father's Name (First, Middle, L	ast)	5.	noe	Maker	18. Mot	her's Name (First, Middle,		anufa Sumame		ing	
lan	ld be ental ked o	To Be	Bernabe Riva							lia Ju					
Maryland 21215-0036	and 2 should be filed within lealth and Mental Hygiene. m 27 le marked other than "her traumatic event, the Mes	-	19a. Inlomant's Name/Relationshi Mirna Flores (1		19		ng Address <i>(Stre</i> 7 Break				-				
re,	of Head of Head of Item		20a. Method ol Disposition	-50	20b. Place cemet	of Dispo	sition (Name of natory or other)	o/ace)	Dat	te	20c. Lo	cation - C	ity or Tov	vn, State	
imo	Pa Pa		1 Donation 5 ☐ Other (Sp.	ecify)		rect	ion Cem	etery							
Baltimore,	permit. Pages 1 and Depertment of Health Important: If Item 27 eny Injury or other tr		21. Signature of Funeral Service L	conduct MC	11464		2. Name and Ad lexandr					-		633 0: 735	ld
,	Physician /Medical		23a Part 1. Enter the disease, or c shock, or heart lailure. List o Immediate Cause (Final disease or condition resulting in death)	omplications that caused nly one cause on each line. aA	10. STR	1 C	Ly	A		respiratory a	rrest,			Approximate Interval Betv Onset and D	veen
H	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	a consequence	e of):	tion								
68760,	cate be executed physicien and the burial-transit	Medical Ex	resulting in death, Last	Due to (or as a	a consequence	e or):									
	certific nding p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			10 00 5000					23d. Date	of deliver	v	
.O. Box	The law requires that the death centificate be executed ate has been signed by the ettending physicien and cage 2 should be detached for use as the burial-transit	Physician/	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregna Other (specify)					Monti			'ear
of Vital Records, P.	quires that the de n signed by the e ald be detached i	þ	Part II. Other significent condition	s contributing to death bu	ut not resulting	in the u	nderlying cause	given in Par	11.		obacco u Yes 2(ute to the	cause of de	eath?
000	aw require is been si 2 should t	Completed								24a. Was		24b. We	ere autop	sy findings a	vailable
R	The lav ate has page 2	E								autor perfo	rmed? 2⁄ΩNo	de	ath?	pletion of ca XIXNo	1039 01
/ita	ysiclen: The is certificate hadirector, page	Be (25. Was case referred to medical examiner?						ce of Death (Check only o				71.71	
of \	Physi this c	7	1 ☐ Yes 2 📉 💥 o	Hospitaf: 1 Inpatie		Outpatier	IL 3L DOA			5 X Resid					
LO	Attending Physiclen: r death. ector: After this certifics by the funeral director, i	tion	27. Manner of Death 1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigs		Year) 200	Injury		ijury at Vork? □Yes 2[d. Describe l	iow injur	y occurred	3		
Division	or Atten after deat Director: in by the	Certification:	3 Suicide 6 Could no determin	ot be Dea Blace of Init	ury - At home, c. (Specify)	larm, str				If. Location (S City or Tox	Street an vn. State	d Number	or Rural	Route Numb	oer,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one) 1 XXCertifying 2 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examination a	ge, deatl and/or in	n occurred at the vestigation, in m	time, date a y opinion, de	and place, an eath occurred	d due to the l at the time,	cause(s) date and	and manr place, an	ner as sta d due to t	ted. the cause(s)	
	Vithi To the	M	29b. Signature and title of certifier	59/		1		ense number			29d. Dat	e signed (Month, D	ay, Year)	
	./		* Kns/	· Chome	_ ~	٧	D50	328		C	25/1	6/0	06		
	5			M.D., 10403	Hospi	tal	Drive,	Suite	103, 0	Clintor	1, M	0 20	735		
*\sqrt{1}	Sta Registi		31. Date filed (Month, Day, Year) MAY 2		ar's Signature	K of	Jacker								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2.0.0.0

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			For State Registrar	State of Mary		artment of H rtificate of I			giene / Reg. No.	JUb	1004
			Decedent's Name (First, Middle, Las	t)				2. Date of De	ath	V	3. Time of Death
	Physici /Medio		Mary		zabeth	Rip		May 15		Year	11:26 A M
1	Examin	er	4a. Facility Name (If not institution, give				Location of Death			ity of Death	
			Southern Marylan 5. Social Security Number 6. Se		yrs. last birthday)	Clint	If Under 24 Hrs.	8 Date of Birt			eorge's
	Funeral Director			□ M 2 T 82	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da Aug 3	, Year) 1923	Virg	olace (State or Foreign Inia Inia
	yland how		10a. State 10b. County	100	. City, Town or Lo	ocation				1	0d. Inside City Limits
	Sa-f.	cto	Maryland Prince	George's	Upper	Marlboro					1 ☐ Yes 2 📉 📉 o
	within 72 hours after death with the Maryland ene. then "netural", or iteme 23e or 28e-f ehow the Mudical Exerction final be rigitlied at	al Director	10e. Street and Number 7917 Trumps h	ill Road		10f. Zip Code 207	72		10g. Citizen d Unite	fWhatCoun ∈d Sta	•
	r deat	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. R	ace - Americ	
920	ours afte al', or if Examin	þ	1 □ Never Married 2 🕅 Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Spec	eify: W	hite
5-0	n 72 hc	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup	du <i>ring</i> most of work	ing	16b. Kind of	Business/Inc	dustry
121	within ene. then	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired Server	"		Gia	ant Fo	od
9	Hygin other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sum	ame)	-
/lan	Mental Mental mrked attic ev	To B	James Olin	Davis			Margi	e Clint	on Hang	ger	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or iteme 23s or 28s-1 show any injury or other traumatic event, the Mudical Examiner must be notified at ance.		19a. Informant's Name/Relationship (7 Robert R. Ripple		19b. Mailir 7917	ng Address (Street of Trumps)	and Number or Rur Hill Road	, Upper	or, City or Tow Marlbo	n, State, Zip Dro, M	Code) D 20772
ore,	iges 1 and of He If item or othe		20a. Method of Disposition 1 XX Murial 2 ☐ Cremation 3 ☐	nemoval irom State		sition (Name of natory or other place	ì		20c. Location		
Ħ	artmer ortant injury		4 □Donation 5 □ Other (Specify 21. Signature of Fuperal Service Lipen			Veteran: Name and Address		-			Maryland
ä	Depa Impo any i		MAD DI	h po		exandria					
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the cone cause on each line.	death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
î	Physician	9 1	Immediate Cause (Final disease or condition resulting in death)	a. ACUTE	MY	CARDI	AL IN	FARCTI) N		Onset and Death
	/Medical Examiner		Tosumy in addition	Due to (or as a cor	sequence of):						
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	and ©	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	accourage of):						
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	tificat ng phy as th	fedical									
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ord	requir	eted	CONFESTIV	E 1) EOR	FAI	LICE			′es 2□No		ably 4 Unknown
Division of Vital Records,	The law ate hes t page 2 s	Somple								prior to cor death? 1 Yes	psy findings available inpletion of cause of
/ita	clan: ertific ector,	Be (25. Was case referred to medical examiner?	11	. (26. Place of Deat	h (Check only o	ne)		
of \	Physi this c	7	1 Yes 2 2010		2 ER/Outpatier		4 Li Nursing Ho				/)
O	Attending Ir death.	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	Worl	Yes 2 □No	28d. Describe h	low injury occ	urrea	
Oivisi	2 = = =	Certification:	3 Suicide 6 Could not be determined		At home, farm, str pecify)	eet, factory, office	:	28f. Location (S City or Ton		nber or Rura	I Route Number,
	To the Hospitel of within 24 hours at To the Funerel Completely filled it		29a. Certifier Certifying Ph	ysician: To the best of my	knowledge, deat	n occurred at the time	ne, date and place,	and due to the	cause(s) and r	nanner as st	ated.
	the Hi hin 24 the Fi	Medicai	one)	and manner stated.							
)	7 × 7 × 0		and this of continue	~		D2	828)	05	15/2	006
	6		30. Name and address of person who and title of certifier. 31. Date filed (Month Day Year)	completed cause of death	(Item 23a) (Type,	Print) 1 pw my f	ors, cl	INJOH	, mo	20	7-37_
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 5 2006	32. Registrar's S	ignature	W.					

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		1. Decedent's Name (First, Middle,	State of Marylan em 26 per verb.	Certific	ale of Dealif	2. Date of De	eath	3. Time of Deat
Physic /Medi Examir	cal	4a. Facility Name (If not institution,	jive street and number)	4b. C	ity, Town, or Location of	Month 5	Day Year	0 11077
Funeral Director		5. Social Security Number 6 220–36–0292	USING HON Sex 7. Age (In yrs. 1□M 2♥F 67	1 e last birthday) If Un Yrs. Monti	der 1 Year If Under 24 hs Days Hours	Hrs. 8. Date of Bir Min. May 18	th 9. Bi	ord nthplace (State or Fore country) Cyland
ahow ed al	٥٢	Usual Residence of Decedent 10a. State 10b. County MD Baltimo		y, Town or Location	n I and s			10d. Inside City Lin
3a or 28a-	I Direct	10e. Street and Number 2825 Michigan Av		10f.	Zip Code 227		10g. Citizen of What C	1 ☐ Yes 21⁄2 Country?
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, it a Madical Extending nated by notified at once.	1 by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was De	cedent of Hispanic Origin pecify Cuban, Mexican, F s 2424No Specify:			ite, etc.
/giene. ier than *natu t, Ine Medical	Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12) 12	crade completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NO Legal Sect	work done during most o Tuse retired)	f working	16b. Kind of Business	s/Industry
Mental Hy harked oth	To Be (17. Father's Name (First, Middle, La Norman Vernon He	ndricks		Antoin	Name (First, Middle, Lette Cern	igula	
iealth and om 27 is m ther traum		19a. Informant's Name/Relationship Donna Fitzgerald	/Daughter	940 Long	cove Rd Gle	n Burnie 1	MD 21060	
Department of Himportant: If Ite any injury or of once.		20a. Method of Disposition ↑□ Sturial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spectrum 21. dignature of Funtral Service Lio	Gle:		emorial Park			ie Md
		23a. Part1. Enter the disease, of co shock, or heart failure. List on	mplications that saysed the death	Do not enter the m	and Address of Facility ose Funeral Hammonds Fe	rry Rd. La	ansdowne ansdowne MD rrest,	21227 Approximate Interval Between
nysician Medical xaminer the prize transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) C. Due to (or as a consequence) Due to (or as a consequence)	ence of):) brain			
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signe d be d	þ	Part II. Other significant conditions	contributing to death but not resu	lting in the underlying	g cause given in Part I.		obacco use contribute to	/
page 2	Completed						osy prior to death?	utopsy findings availa completion of cause 25 No
	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3 ☐ [1 Oth	Death Check only or	ne dence 6 □Other (Spe	- 4.1
ath. r: After th e funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		now injury occurred	ciry)
# O =	Ħ	3 Suicide 6 Could not determined	building, etc. (Specify,			City or Tow		
rai Directo	OL			rledge, death occurre	d at the time, date and pl	ace, and due to the o	cause(s) and manner as	
e Funeral Directo	OL	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my know miner: On the basis of examinati and manner stated.	on and/or investigation	on, in my opinion, death o	ccurred at the time, o	date and place, and due	stated. to the cause(s)
in 24 hours he Funeral pletely filled	ledical C	Z Medical Exa	miller: On the basis of examinati	on and/or investigation	on, in my opinion, death of the second of th	ccurred at the time, o	29d. Date signed (Month	to the cause(s)

			1 - For State Registrar	State of Marylar		artment of H rtificate of		•	giene Reg. No. 2	06	16545
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last, Richard Da 4a. Fecility Name (If not institution, give) 5162 Brookway Un:	rrell Shelto	n	4b. City, Town, o	or Location of Dea		21 Day	2006 ty of Death ward	3. Time of Death 11:06 A ^M
	Funeral Director		5. Social Security Number 6. Set 231–78–2579	7. Age (In yrs. M 2□ F		If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Da	th ly, Year) 7,1952	9. Birthpla Count Virg	ace (State or Foreign ry) inia
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or itema 23a or 28a-f show eny injury or other traumatic event. The Madical Examinar must be multiled at once.	leted by Funeral Director	Maryland Howard 10e. Street and Number 5162 Brookway Un	Lt 2 12. Was Decedent Ever in U Armed Forces? 1 Yes, Give Year or Dates:	.S. 13.	Docation Dlumbia 10f. Zip Code 2104 Was Decedent of H If Yes, specify Cube 1 Yes 2 No Dent's Usual Occup kind of work done a	lispanic Origin? (an, Mexican, Pue Specity:		Specify: Wh		
yland 212	uld be filed withi Mental Hygiene. Irked other than tic event, the M	To Be Completed	17. Father's Name (First, Middle, Last) Darrell Sheltor	Cottege (1-4or 5+) 5+		ms Adjus	ter 18. Mother's Na	me (First, Middle,	Insur Maiden Suma		
ballimore, Mary	permit. Pages 1 and 2 sho Department of Health and I Important: If Item 27 ie ma eny injury or other trauma once.		19a. Informant's Name/Relationship (Ty, Mark Shelton (br. 20a. Method of Disposition XX Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	other) emoval from State 01 Me	10010 Place of Disponentery, crent d Domitmorial	ng Address (Street is Herding sition (Name of natory or other place) Gardens Name and Address Lizke Fur	Row Co	lumbia, l	Mary1an 20c. Location Roanok	d 2104 - City or Tow	rn, State
ļ	Physician /Medical Examiner	Examiner	23a. Part I. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a)	uence of):	er the mode of dyin	g, such as cardia	c or respiratory ar	rest,	1	and 21045 Approximate nterval Between Doset and Death
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ii necolus,	sicien: The law requires in scenificate hes been signe lirector, page 2 should be on the control of the control	Completed by	Part II. Other significant conditions con	induting to death but not rest	alting in the un	derlying cause give	en in Part I.	1 TY	es 2 No nn 24b.	3 Probab Were autops prior to comp death?	cause of death? oly 4 [Minknown y findings available oletion of cause of
2010	To the note purpose of the following registers: the within 24 hours after death. To the Funeral Director: After this certificate he completely tilled in by the funeral director, page	To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	or: 4 🗆 Nursing F	ath (Check only or tome 5 (V) Reside 28d. Describe he	ne) ence 6 □Oth	er (Specify)	
	within 24 hours after death. To the Funeral Director: A completely tilled in by the funeral back to the f	edical Certification:	3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Examin	28e. Ptace of Injury - At ho building, etc. (Specify cian: To the best of my knower: On the basis of examinat and manner state)	viedge death	occurred at the tim	e, date and place	28f. Location (Si City or Town	n, State)		
4 6	within 24	Medi	29b. Signature and title of certifier And I Mortor	M.D.		29c. License	number	2	9d. Date signed	(Month, Da	y, Year)
	Stat Registra	e	30. Name and address of person who cor BERT F. MORT 31. Date filed (Month, Day, Year)	npleted cause of death (Item 2000 / 1000 1000 1000 1000 1000 1000 100	23a) (Type, F 602 Mg	Print) WCLALR	DR: E	LICOTY	CETY /	10,21	64B

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. -2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** H. SCHLOTTHOBER WILLIAM 16 15 PM 21 2006 MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 11€M 2□ F Director 213-20-8253 79 08/31/1926 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ed other than "naturel", or Items 23a or 28a-f shows event, the Medical Experience result be excitited at 1 ☐ Yes 2 X No Ellicott City MD Howard Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7740 Mayfair Cr. 21043 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status within 72 hours after 1V Yes 2 No If Yes, Give 1943–47 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Š Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carman B&O Railroad 8 es 1 and 2 should be filed w of Health and Mental Hygier fitem 27 Is marked other ti 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles L. Schlotthober Margaret Norwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Emma Schlotthober / Wife 7740 Mayfair Cr., Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 05/26/2006 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Gry L. Kautman Funeral Home at Meadowridge Manorial Park, IN M01378 7250 Washington Blvd., Elkridge, MD 21075 Approximate Interval Between Onset and Death Ant1. Enter the discusse, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fource. List only one cause on each line. Immediate Cause (Final Physician CARDIORESPIRATORY 16 HOURS /Medical resulting in death) Due to (or as a consequence of): **Examiner** ISCHEMIC BOWEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ARTERY CORONARY that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Completed by þ LUNG CANCER, ASSESTOSIC 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No P 1 🗌 Yes 1 npatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3. Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number hen Mahy MD-Intermist D64220 MAY 21, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 CEDAR LANE, COLUMBIA, MD 21044 JUAN M. CABRERA, M.D.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAY 2 5 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 23, Year Virginia E. Stotler 2006 822PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Catonsville Commons Nursing Home Catonsville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) 214-12-1066 1 ☐ M 2 ☑ F 88 Director 4-15-1918 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County or 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner nust be nutified at MD Director Baltimore Catonsville 1 ☐ Yes 2☐No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1931 Old Frederick Rd. Items 23a 21228 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "neturel", or iten eny injury or other traumatic event, the Mcdical Examinations. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2020No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ira Evans Violet V. Norris ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betsy Mitchell/ Friend 1931 Old Frederick Rd. Catonsville, MD 21228 20b. Place of Disposition (Name of cametery, crematory or other place)
Crestlawn Memorial
Gardens 20a. Method of Disposition 20c. Location - City or Town, State MBurial 2 □Cremation 3 □Removal from State 5-26-2006 Marriottsville, MD 4 Departion 5 ☐ Other (Specify) runeral Se Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Friysician disease or condition resulting in death) lew dows /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I 9 Unknown 9 Unknown þ neral Director: After this certificete has been signed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ diseone Be Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No 1□ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a b Funeral C 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cicetra Kapa MD 12754 May 24, 2006 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CONTINA RATA MD 43b 7 HOTING FUNG Baltmone MD - & 1227 31. Date filed (Month, Day Registrar

			1- Stat Amend Item#4a		Marylan 2 5 &1	d/Depa Oe per	artmen EH C rtificate	t of H 856 e of L	ealth a Death	and M -06 C	ental Hy	giene Reg. No	200	5	16548
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	/Medi	cal	Dorothy K. Ster								May 2		2006		230 PM
	Examir	ner	4a. Facility Name (If not institution, give		er)		4b. City,		Location of			4c.	. County of D	eath	
	Funeral		5515 Delores Ave 5. Social Security Number 6. S	ex 7. /	Age (In yrs. I	ast birthday)	If Under	1 Year	butu If Under		8. Date of Birt	 h		time	
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	Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic events.	1	21. Signature of Funeral Service Lisso	TA				Address	s of Facility	y Ambr	ose Fur	nera	1 Home	υ Tn	C
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DIVISION OF VICE To the Hospital or Attending Physician:	within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exemi	sicien: To the best ner: On the basis of and manner si	or examinatio	ledge, death on and/or inve	occurred at estigation, in	the time my opir	, date and nion, death	place, and occurred	d due to the ca at the time, da	use(s) a te and p	and manner a place, and du	s stated. to the o	cause(s)
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	φ		30. Name and address of person who co	empleted cause of	death (Item 2		sele	, le	rel	du:	4100	Cox	noull	10	2,276
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State of Maryland / Department of Health and Mental Hygiene) State Registrar Amend #1 Per PHy G856 6/21/06 rtifficate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Doris A. Stabb 2006 Doris A. Staab 10:00 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4 Trotting Horse Court Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Nov 10, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** , 1922 215-18-7548 1 ☐ M 2 🛱 F 83 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examinar must be notified at Directo 1 ☐ Yes 2X No Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 606 Wallerson Road Items 23a 21228 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No þ Specify Specify: White 3 Widowed 4 □ Divorced "natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Charles Drimal 2 Mary Tuma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health i Carol Ann Przybyla, Daughter 817 Hidden Bluff Circle Catonsville, MD 21228 ce of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of important: If It any Injury or o one. IX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/27/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor MacNabb Funeral Home P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certiticate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physicien for use as the buria Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death Month Day Year signed by the e 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown certificate has birector, page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other \(\) Residence Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. To the Funeral Director: 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a 29a, Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 94 29b. Signature and title of certifie, 29c. License number D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGNES 900 CATON AVE BALTIMORE MD 21229 EW COLE 31. Date filed (Month, Day, Year) Registrar's Signature State 5 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 2:02 PM 23, 2006 Glenda Elaine Stevenson May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Laurel 3 Dell Place If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🛣 F 8, Pennsylvania Director 219-64-3457 64 May Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1 Yes 2 No Directo Prince George's Laurel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a United States 3 Dell Place 20707 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 No Yes, Give Specify Specify lf Yes, Givo Year or Dates: 3 Widowed 4 Divorced White "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Disabled n/a permit. Pages 1 and 2 should be filled Department of Health and Mental Hygin Important: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kathryn Zimmerman 2 Ε. Stevenson Hilda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurel, Maryland 20707 Hilda K. Stevenson/mother 3 Dell Place 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 5/25/2006 Odenton, Maryland 21. Signature of Funeral Service Licens Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 once. any uante (K tiomar Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician Pneumonia resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Lung Disease Sequentially list conditions, n any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 ☐ Yes 2X No 3 Probably 4 Unknown Metastatic Colon Cancer 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 Yes 2 XNo 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 XNo P 3□ DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: in by the within 24 hours a To the Funeral I the 2

4 Homicide

29b. Signature and title of certifier

29a. Certifier

Medicai

Baltimore, Maryland 21215-0036

State

Francine Higgs-Shipman, M.D. 11700 Beltsville Drive, Beltsville, MD 20705 31. Date filed (Month, Day, Year) MAY 2 5 32/Registrar's Signature 5 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



menon

1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D28079

29d. Date signed (Month, Day, Year)

May 25, 2006

Registrar

			1 - For State Registrar	State of Maryland		t of Health			16551
	Physic	ian	Decedent's Name (First, Middle, Last	st)			2. Date of De Month	aath Day Yea	3. Time of Death
	/Medi		BEDFORD	HENRY	SMITH	-)	05	21 200	. 11/2 - A 11
	Exami	ner	4a. Facility Name (If not institution, give	4	4b. City,	Town, or Location	of Death	4c. County of De	ath
	Funeval		5. Social Security Number 6. S	ex 7. Age (In yrs. last	t birthday) If Under	+more	or 24 Hrs. 8. Date of Bir	MA	
2	Funeral Director			⊠M 2□F \$3	Yrs. Months	Days Hours	Min. (Month, Da		irthplace (State or Foreign Country)
7	<u>p</u>		Usual Residence of Decedent				1/19/	1700	VI
	aryla show	2	10a. State 10b. County	10c. City, T	fown or Location				10d. Inside City Limits
	the M	ecto	10e. Street and Number	Bal	timore			-	1 ☐ Yes 2 ☑ No
	with a or	Funeral Director)	10f. Zip	Code		10g. Citizen of What (Country?
	death	lera	809 A. BROOKS	12. Was Decedent Ever in U.S.	13. Was Deced	ant of Hispanic O	rigin? (Specify Yes or No	USA 14 Bace - An	nerican Indian,
9	after or its	Ē	1 ☐ Never Married 2 🗷 Married	Armed Forces? 1 Yes 2 No	If Yes, speci	fy Cuban, Mexica	an, Puerto Rican, etc.)	Black, Wh	
5-0036	72 hours after death with the Maryland naturel', or items 23a or 28e-f show disal Examinar must be coullied at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2	No Specify	y:	Specify: BI	ack
5-	nati	Completed	15. Decedent's Ed (Specify only highest gra	ucation 1 de completed)	6a. Decedent's Usual (Give kind of work	k done durina mo	est of working	16b. Kind of Busines	s/Industry
2121	within ene. then "	E D	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use	e retired)		1./001	
9	filed with Hygiene. other ther		17. Father's Name (First, Middle, Last)		mecha		ner's Name (First, Middle,		puse
an	lid be fental rked o	To Be	Samuel Smit	h			erilena P	ROWN	
Maryland	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, Ita M	-	19a. Informant's Name/Relationship (7	ype, Print) 1	19b. Mailing Address		per or Rural Route Number		Zip Code)
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiere. Item 27 is marked other then "naturel", or items 23s or 28s-f show other traumatic event, Ira Medical Examinar minist be notified as		Evelyn Smith	8	09 A. BR	ooks he	are Prilting	RE MA 2	1217
ore	0 0		20a. Method of isposition 1 ■ Burial 2 □ Cremation 3 □	2000	e of Disposition (Name etery, crematory or oth	e of ner place)	Date	20c. Location - City o	r Town, State
Baltimore,			4 □Donation 5 □Other (Specify	Gaza	sison Cen	etery !	5/31/06	Dwings Mi	ILS, MD
Bal	permit. Departr Importa		21. Signature of Funeral Service Licen	500	22. Name and	Address of Facil	& Funeral S	SVC	
	VI.		23a. Part1. Enter the disease, or comp	lications that caused the death. F	5151 V	atto XOH	. P.Ke Batt	more MD	
	Physician		Immediate Cause (Final	one cause on each line.	l	e.	s cardiac or respiratory at	rest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. UCOTE 13	eukem	الص			4 years
	Examiner		0	b	33 31).				J
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ce of).				
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C					
8760,	death certificate be executed e attending physicien and id for use as the burial-transit			Due to (or as a consequent	ce or):				
687	ficate p phys	Physician/Medical		d					
Вох	eath certific attending pl	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of de	friend
		icia	in the past 12 months?	1 Live birth 2 ☐ Fetal dea 4 Pregnant at time of death				Month	Day Year
P.O.	by by	hys	9 Unknown	9□ Unknown					
	res tha igned be del		Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlying cau	ise given in Part I	I. 23e. Did to	bacco use contribute to	the cause of death?
ord	w requir been si should	ted	arremia, T	Mombocyt	openia		1 🗆 Y	es 2⊡Kno 3⊡P	robably 4 🗆 Unknown
of Vital Records,	has b	Completed by	Infection	J	U		24a. Was a	an 24b. Were a	utopsy findings available completion of cause of
<u>a</u>	T at a)				perfor 1 ☐ Yes	med? death?	2 □ No
₹	Physicien: this certificatal director.	Be.	25. Was case referred to medical examiner?	Hospital:		Othor	e of Death (Check only or		
ō	Phys or this oral dir	. To	1 Tyes 2 No 27. Manner of Death	1 patient 2 ER/	Outpatient 3 DOA	4 LINC	ursing Home 5 Reside	ence 6 Other (Spe	cify)
Division	Attending or death. ector: After by the funer	Certification:	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	: Injury at Work? 1 Yes 2		ow injury occurred	
<u>×</u>	Attandi er death. rector: A by the fu	Iffica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory,	office	28f. Location (S	treet and Number or Re	aral Route Number,
ā	ital or irs afte rel Dir led in I	Cer					City or Town		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowled ner: On the basis of examination and mapper stated	ige, death occurred at and/or investigation, in	the time; date and my opinion, dea	d place, and due to the eath occurred at the time. d	audu(s) and manner as ate and place, and due	stated. to the cause(s)
	omple	Mec	29b. Signature and title of certifier	and manner stated.		icense number		9d. Date signed (Mont	
	F 5 F 6		M P	- 1100:00 = 0.00		-		J. J	-/
_	1		30. Name and address of person who co	mpleted cause of death (Item 23a		V DO	063083	3/25	106
L	1		DP. HORIba	umi	ms				
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature					
DHY	Registra 1H 17 Rev 1/20		MAY 2 5 2006	Server St Apre	di'				

ORIGINAL

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		1	For State Registrar	State of	Maryland / I	Departme <i>Certifica</i>			na M		giene/ Reg. No.	JUb	1000
表。	*		Decedent's Name (First, Middle	e, Last)					1	2. Date of De	ath		3. Time of Death
	ysicia		AISMA	STEVENS	SON					Month 0.5	Day 2_1	2006	11:28 AM
	Medic camine	4	4a. Facility Name (If not institution			4b. Cit	y, Town, or	Location of	Death			nty of Death	1
	Carrille	51	FUTURE CA				BALTI	MORE				N/A	
Fun	eral		5. Social Security Number	6. Sex	7. Age (In yrs. last bit		er 1 Year	If Under 2	Min.	8. Date of Bir (Month, Da	th V Year)	9. Birthp	place (State or Foreign
Dire	_		220-11-3401	1 □ M 2 XX	20	Yrs.	Days	Hours	IVIIII.	MAY 6	1986		RYLAND
ē.,		-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Location						- 1	Od. Inside City Limits
aryla ehov	1		10a. State 10b. County		Toc. City, Tow								1 X Yes 2 ☐ No
M er 1-e8	allie	St	MARYLAND N/A			BALTIM					10g. Citizen	of Milhor Cour	
with ti	2	吉	10e. Street and Number			101. 2	Lip Code 212	22			-	S.A.	nry :
ILE 13-0000 within 72 hours after death with the Maryland one.	Ħ	Funeral Director	327 S MONRO		dent Ever in U.S.	13 Was Dec			in? (Soa	cify Yes or No		Race - Americ	can Indian.
ter de	Tage 1	ű	11. Marital Status p(XNever Married 2 ☐ Marri	Armed For	ces?	If Yes, sp	ecity Cuba	n, Mexican,	Puerto F	cify Yes or No Rican, etc.)	E	Black, White,	
irs af	Na.	by	3 Widowed 4 Divorced	If Yes, Give	9	1 🗆 Yes	2XNo	Specify:			Spe	cify: BLA	CK
2 hou	Sal	ted		it's Education	16a	. Decedent's Us	ual Occup	ation	af worker	20	16b. Kind of	Business/In	dustry
를 등 다. 다.	Med	Completed	Elementary/Secondary (0-12)	st grade completed) College (1-	4or 5+)	(Give kind of v life. DO NOT	use retired	during most	OI WOIKII	19			
A with	2	5	unknown			DISA	BLED					N/A	
be filed at Hygi	event, the Medical Evandinar must be notified at	Be (17. Father's Name (First, Middle,	Last)				18. Mother	r's Name	(First, Middle	, Maiden Sum	iame)	
Ment Ment	atic	<u>P</u>	BENJAMIN STE	VENSON				CYN'	THIA	BLUE			
2 should be a name of in marked of	E S		19a. Informant's Name/Relations	ship (Type, Print)	198	. Mailing Addre	ss (Street	and Number	r or Rura	l Route Numb	er, City or Tov	vn, State, Zip	Code)
and and ealth	other traumatic	- 4	Anna L. Veney/	Grandmothe				oe St		altimo		_	
Dailiniore, Marylania (17.15-0050) permit. Pages 1 and 2 should be filed within 72 hours alf Department of Health and Mental Hygiestament of Health and Mental Hygiesta. Important: if item 27 is marked other then "naturel; or important: all tem 27 is marked other then "naturel; or important: all tem 27 is marked other then "naturel; or important: all tem 27 is marked other then "naturel; or important and all temperatures."	or of		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation	3 □Removal from S	comete	f Disposition (N ery, crematory of		ce)	- 0	ate	20c. Locatio	n - City or To	own, State
Pag ment	nux		4 Donation 5 Other (S	Specify)		CREMAT				4-06	BALTIN	ORE, I	MARYLAND
armit.	eny inj pnce.		21. Signature of Funeral Service	Licensee				ss of Facility		MUNITOV	FINED	T. HOM	F D A
1 40 E	a a		2 Part 1. Enter the disease, o shock, or heart failure. List	C/3-						MUNITY		T. Company	Approximate
Physic /Med Exam	dical	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (d	or as a consequence	of):	EFFIC	-12NC)	<i>y</i> \$	YNDR	3 ME		Onset and Death
The death certific	ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	1☐Live bi	come of pregnancy rth 2 □Fetal death ant at time of death wn	n 3 Ectopic 5 Other (,				Date of delive	ery Day Year
uires that	peq	by	Part II. Other significant conditions SEPTIC	•	ath but not resulting	in the underlying	cause giv	en in Part I.			obacco use c		he cause of death? cably 4 Ptnknown
as t a	ge 2 should t	Completed	CARDIO	MYOPATH	7					24a. Was		b. Were auto prior to co death?	opsy findings available impletion of cause of
VITAL HO	r, page			The state of the s						1 ☐ Yes	2 No	1 🗆 Yes	2□ No
VII	director,	Be	25. Was case referred to medica examiner?	Hospital:			Oth			Check only			
OT VITA Physicien:	722	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date o		utpatient 3 Time of	DUA	4 LE NUI		ne 5 Resi			(y)
ding Affer	fune	tlon	1 Natural 5 Pendi	/Adont		Injury	28c. Injur Wor	k? Yes 2∐1					
VISION Attending r death.	ed in by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Could	not be 200 Place	of Injury - At home, f					28f. Location (Street and Nu	mber or Rura	al Route Number,
after A Direct	in by	ertif	4 Homicide determ	mined 289. Flace buildin	ng, etc. (Specify)	a, 5.1.55t, 145t	ory, omoo				wπ, State)		,
DIVIS To the Hospital or Atte within 24 hours after de To the Funeret Directo	tely filled	edicai Co		ng Physician: To the I Examiner: On the ba	sis of examination a								
thin 2	mple	Med	29b. Signature and title of certific	and manr	ier stateu.		29c. Licens	e number			29d. Date sig	ned (Month,	Day, Year)
7 × 5	8		N 1 1 1 1								5/2		
	1,			v. D	- at de sah // 00-)	(True Delet)	DO	05910	++		514	>106	>
	M		30. Name and address of person	who completed caus	e ot death (Item 23a)	(Type, Print)	ac 4	Dane	0	C.(500:	A	MA -	7 112/
			31. Date filed (Month, Day, Year	A	BUSINE egistrar's Signature	>> CEN	15/0	シーし	ي K	21212/4	1 sun	WAD	11176
Trust 3 6	Sta												

DHMH 17 Rev 1/2001

		4	Ameria i tems 10a State of M I = State Registrar		ger Th 8857-7-9-06 artment of Health and rtificate of Death		giene () () ()	16553
	Physici	an	Decedent's Name (First, Middle, Last) ANNE	SMITH		2. Date of Dea Month MAY		3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give street and number		4b. City, Town, or Location of Dea	1	4c. County of Dea	
40	謝		NORTH ARUNDAL HEALTH AND REHABI		GLEN BURNIE If Under 1 Year If Under 24 Hrs		ANNE ARUNE	
	uneral irector		5. Social Security Number 6. Sex 1 ☐ M 2	ge (In yrs. last birthday) 80 Yrs.	Months Days Hours Min		1926 PENN	thplace (State or Foreigr puntry) SYLVANIA
yland	ehow		10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits
e Mar	or 28e-f eho	Director	Florida ANNE ARUNDAL	GLEN BURNT	Punta Gorda			¹X□Yes 2□No
with th	B or 2		10e. Street and Number 2000 Via Sevill	.e	10f. Zip Code 33950		10g. Citizen of What Co	ountry?
eath	ns 23,	erai	313 HOSPITAL DRIVE- 11. Marital Status 12. Was Deceden	t Ever in U.S. 13	Was Decedent of Hispanic Origin? (5	Specify Yes or No-	U.S.A.	erican Indian
d 21215-0036 filed within 72 hours after death with the Maryland Hydiene.	rai', or items 23a Examiner must	d by Funeral	1 Never Married 2 Married 1 Yes 2 Married 3 M Widowed 4 Divorced Amed Forces 1 Yes 2 New Year or Dates:	No	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	to Rican, etc.)		
Maryland 21215-0036 of 2 should be filed within 72 hours aft the and Mental Hydiene.	r than "natur Its Mudical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	5+) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking	16b. Kind of Business FEDERAL GO	
d 2 Hygie	other vent,	Be Co	14 17. Father's Name (First, Middle, Last)	EXECU	TIVE ASSISTANT 18. Mother's Na	me (First, Middle,		VERIMENT
aryland should be	7 is markad othe treumatic avent,	To B	METRO NADOLNY		MARY MARK	0		
Mary 2 sho	le me		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or R			Zip Code)
~	item 27 other tre		JAMES SMITH / SON 20a. Method of Disposition	1268 3 20b. Place of Dispo		IAPOLIS M	D 21401 20c. Location - City or	Tour State
2 2 2			1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crei	natory or other place)	; /	PUNTA GORDA,	
Baltir Permit. F Departme	Important: ti any injury or QDCs.		21. Signature of Fun el Service Licensee		Name and Address of Facility ECK FUNERAL HOME	2/12000		_
Ö	any i		Man & hope.		01 SANDY SPRING ROAD	LAUREL MA	RYLAND 20707	
/M Exa	sician edical miner	iner	resulting in death) Due to (or a Sequentially list conditions.	p PANCREATIC C. s a consequence of):	ANCER			Interval Between Onset and Death
68760 , <i>y</i> ficate be executed	physicien and is the burial-transit	edical Examiner	that initiated events c.	s a consequence of):				
Division of Vital Records, P.O. Box 687 Hospital or Attending Physician: The law requires that the death certificate 19 hours after death.	by the attending physicached for use as the b	Physician/Medical		2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
IS, P	gned be de	þ	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given in Part I.		bacco use contribute to	the cause of death?
Division of Vital Records, for Attending Physician: The law requires taller death.	has been si ge 2 should 1	ompieted				24a. Was a autop:	an 24b. Were au	itopsy findings available completion of cause of
is	certificate ha	ပိ	25. Was case referred to medical		OC Place of Do	1 Yes	2 No 1 □ Yes	2 No
f Vji	₩ 5	0 8	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpat	ient 2 ER/Outpatier	0.1	ath Check only or	ence 6 □Other (Spe	cify)
ision Of Mending Ph	After th funeral	ertification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ury 28b. Time of Injury			ow injury occurred	
Divis Nor Atte	in b	ertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Ir building, e	njury - At home, farm, str tc. (Specify)	eet, factory, office	28f. Location (S City or Tow	treet and Number or Ru n, State)	iral Route Number,
he Hospita n 24 hours	Funerel	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner s	of examination and/or in	n occurred at the time, date and place vestigation, in my opinion, death occ	e, and due to the curred at the time, o	ause(s) and manner as late and place, and due	stated. to the cause(s)
To the	To the	M	29b. Signature and little of certifier	2_	29c. License number D51596		29d. Date signed (Mont. AY 19, 2006	h, Day, Year)
	0		30. Name and address of person who completed cause of K. AMBALAVANAR, 7845 OAKWOOD RO	death (Item 23a) (Type. DAD, 103, GLEN	Print) BURNIE, MD 20784			

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

State of Maryland / Department of Health and Mental 1- State Registrar Certificate of Death		Z U U U	16554
1. Decedent's Name (First, Middle, Last)	Reg. I	No.	3. Time of Death
Physician Fontella Seta May	24	2006 Year	7:25 A M
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dear	h
Greater Baltimore Medical Center Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date	of Birth	Baltin 9. Bir	hplace (State or Foreign
Funeral Director 213-(0)-(623) 1 M 2 F 5 H Yrs. Months Days Hours Min. 8 Morts Director	th, Day, Yea	151 m	aryland
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lecation			10d. Inside City Limits
Baltimore Baltimore			1 Yes 2 No
10a. State 10b. County 10c. City, Town or Lecation 10a. State 10b. County 10c. City, Town or Lecation 10b. Street and Number 10c. City, Town or Lecation 10c. Street and Number 10c. City, Town or Lecation 10c. Street and Number 10c. City, Town or Lecation	10g. (Citizen of What Co	puntry?
The state of the s	or No-	14. Race - Ame	rican Indian
Armed Forces? Armed Forces? If Yes, specify Cuben, Mexican, Puero Rican, e 1 Yes 2 No 1 Yes 2 No Specify:	c.)	Black, Whit	
Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No No 1 Yes 2 No No No No No No No		Specify: UU	,,,,,
(Gene kind of work done during most of working	16b.	Kind of Business	Industry
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Eather's Name (First, Middle, Lastle,) 18. Mother's Name (First, Middle, Lastle,)		att	ome
Elementary/Secondary (0-12) College (1445+) To be the state of the st	diddle, Maid	en Sumame)	amales
19a. Informant's Name/Relationship (Type, Print) DIAM: 19b. Malling Address Street and Number or Rural Route	Vumber, City	y or Town, State, 2	Zip Code)
Jennifer Hecher 80 Put Hil A 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory of other place) Date	e. Bo	Itimore	mp2 1234
1 M Burial 2 Cremation 3 Removal from State	20c.	Location - City or	own, State
4 Donation 5 Other (Specify)	1 ch	reville	$_{mD}$
22. Name and Action Lacipumero	Kvill		21234
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respira shock, or heart failure. List only one cause on each line	ory arrest,		Approximate Interval Between
Physician [Medical Immediate Cause (Final disease or condition resulting in death) Pha my ngen (a no in term 2) a. Due to (oras a sonsequence of):			TWO Youns
Due to (or/as a consequence of):			,
Sequentially list conditions, of if any, leading to immediate Cause. Enter Underlying Due to (or as a consequence of):			
Sequentially is contained. Journal of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Og. 4			
9 5 9 9			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 20 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Pregnant at time of death 5 Other (specify) 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Efeat death 3 Ectopic pregnancy 1 Live birth 2 Efeat death 3 Ectopic pregnancy 1 Live birth 2 Efeat death 3 Ectopic pregnancy 1 Live birth 2 Efeat death 3 Ectopic pregnancy 1 Live birth 2 Efeat death 3 Ectopic pregnancy 1 Live birth 2 Efeat de		23d. Date of del Month	ivery Day Year
O g for the section of the section o			
D = D = D = D = D = D = D = D = D = D =	Did tobacco	o use contribute to	the cause of death?
order signature de la constant de la	1 Yes	2 No 3 Pr	obably 4 Unknown
The law requirements of the control	Was an autopsy performed?	prior to d	topsy findings available completion of cause of
1 D S D S D S D S D S D S D S D S D S D	res 2	lo 1 ☐ Yes	2□ No
examiner? Column		6 □Other (Spec	cify)
28d. Des (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Des	cribe how in	jury occurred	
O D G G G G G G G G G G G G G G G G G G	tion (Street	and Number or Ru	ral Route Number,
28d. Des	or Town, Sta	ite)	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to (Check only 2) Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the	time date a	nd place, and due	to the cause(s)
29b. Signature and title of certifier 29c. License number	29d. D	ate signed (Monti	n, Day, Year)
• "Mulall G. Franc, M.D. 017873	101	Ay 24) 21	606
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manahull A. Levive 6569 North Charles & Suite 205	Bal	figure;	4D 21204
and manner stated. 29b. Signature and title of certifier 29c. License number 10 17 57 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manghull A. Levice USC9 North Charles St. Suite 205 State Registrar 31. Date filled (Month, Day, Year) MAY 2 5 2006 32. Registrar's Signature MAY 2 5 2006		•	

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** Clarence J. Shook May 12:30anM 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Randallstown
If Under 1 Year | If Under 24 Hrs.
Wonths Days Hours Min. Genesis Health Care Baltimore 8. Date of Birth (Month, Day, Year) March 20, 5. Social Security Number Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last birthday) **Funeral** 150 M 2□ F Months 217-14-5507 94 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28e-f ehow traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1006 Collwood Road 21228 USA or iteme 23a death Funeral permit. Peges 1 and 2 should be filed within 72 hours after death Dependent of Heelth and Mental Hygiene. Important: If Item 27 is marked other them. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: WW 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Completed by WWII 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

16a. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bank Teller 12 Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Daniel C. Shook ٥ Mary Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Donald J. Shook (Nephew) 1924 Gardenia St., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Removal from State Lake View Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 5/24/2006 Sykesville, MD 21. Signature of Funeral Service Licensee AATGARD Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)
Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atheroscierotic cardiovascular disease Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physicien and Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebrovascular 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

1 Yes 2 No certificete 2□ No 1 Yes Director: Atter this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 ☐ Yes 2 No ဥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funaral Director: Af 1 ☐ Yes 2 ☐ No investigation 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified everso May Name and address of person who completed cause of death (Item 23a) (Type, Print) xevenso 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State 5 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 31 per DVR, G855, 05/26/106dbb f Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SIMMS Month 05 -Physician OZ 5:40 AM -2006 /Medical 4a. Fecility Name (If not institution, give street and numb 4c. County of Death 4b. City, Town, or Location of Death Examiner 6525 Ridgeborne

5. Social Security Number 6. Sex seda Year If Under 2 Z Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) Funeral 217-20-1747 Months Days 1 M 2 P 87 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits d other than "naturel", or iteme 23a or 28a-f show event, the Medical Examiner must be notified at Baltimore 1 1 No Director MI 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3329 Mondawmin WSA 21216 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. should be filed within 72 hours after and Mental Hygiene, marked other then "naturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ NO Specify: þ Specify: 3 ₩idowed 4 Divorced BIK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Patient Coordinat Spring Grove St. Hiso 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be f Depertment of Health and Mental I Importent: If Item 27 is marked of 2040 Wade Hexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6825 Rosedale MD. 21237 rwendolyn DIMMS idgebrae Dr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Deurial 2 Cremation 3 Removal from State Injury or butus Cemeters 5/12/06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Famility Corrected Service License 8728 Liberty Rd. Pandall's town mb

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest, Approximate Cause (Final International Ca any la Rd. Randallstown md. 21133 Approximate Interval Between Onset and Death mediate Cause (Final **Physician** MEZOS ENTRE 6 Mcs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. N Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has t autopsy performed? 1 Yes 20 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 2 1 ☐ Yes 2 X No After this funeral dir 4 Nursing Home 5 Residence 6 Sother (Specify) HOSPUS 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Oescribe how injury occurred Certification: No the Hospital or Attanding I within 24 hours after death.
To the Funeral Director: After Natural 2 Accident 5 Pending W NUM 1 □ Yes 2 □ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide WIN hin 24 hours aft the Funeral Di mpletely filled in 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MAY 2 5 2006

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31. Date filed (Month, Day, Year)

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020	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or itams 23a or 28a-f show event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed X4X Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	∍s? □ ^{No} 195	3 1	Was Deced f Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or N Rican, etc.)		14. Rac	e - Americ ck, White,	an Indian, etc.	
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Division of Vital Records, P.O. Box 68760, <	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

For State Registrar	mend Ti	State o tem #8&18	f Marylan ner FH						gienez Reg. No.	006	16559
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	If not institution	n, give street and nu	mber)		4b. City, Town	, or Location	of Death		4c. Co	ounty of Death)
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5. Social Security I	299	6. Sex 1 🛣 M 2 🗆 F	7. Age (In yrs. 84	Yrs.	Months Da		Min.	8. Date of Bird (Month, Da Mar . 22	192	Cal	place (State or Foreign intry) MD
Usual Residence of	10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
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17. Father's Name		Last)		1 20006	DCLV		ner's Name	e (First, Middle,			TATCE
Henry Sc	hneide	r				unl	cnow n	Helen	C.	Pyle	
19a. Informant's N	lame/Relations	hip (Type, Print)		19b. Mailir	ng Address (Str	et and Numb	oer or Rura	al Route Numbe			p Code)
Mrs. Phy	llis L	. Cail/ Da					n, MD	20759			
20a. Method of Dis	•	3 □Removal from	۱ ۸	lace of Dispo emetery, crer	osition (Name of matory or other	olace)	May	Date 26	20c. Locat	ion - City or T	own, State
`4 □Donation				yland	Vet. Ce	m.	2006		Crown	sville	, MD
21. Signature 15	ung I Service	Licensee	U	6/4/1	2. Name and Ad		01	ngleton Glen B			
23a. Part 1. Enter	the disease, or	complications that of	aused the deat							, III 2.	Approximate Interval Between
Sequentially list or if any, leading to it cause. Enter Und Cause (Disease ot that initiated event resulting in death)	mmediate erlying r injury s	C	(or as a conseq								= -
IF FEMALE: 23b. Was deceded in the past 1/2 1 Yes 2 9 Unknown Part II. Other sign RECTAL	? months? □ No	1 Live t	tcome of pregna pirth 2 ☐ Feta nant at time of down	Ideath 3[□Ectopic pregna □ Other (specify				23d	. Date of deliv Month	ery Day Year
Part II. Other sign		RENAL CA		ulting in the u	nderlying cause	given in Part	I.	1	es 2□N		the cause of death?
					·				an 2 sy med? 2 XNo	4b. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of 2 \(\square\$ No
25. Was case refe examiner?	rred to medical						e of Death	(Check only o	пе)		
1 Yes 2				ER/Outpatien	" O D DON			me 5 Resid			fy)
27. Manner of Dea	tn 5 □ Pendin investig	ig .	th, Day Year)	28b. Time of Injury		ury at Vork? Yes 2	1	28d. Describe h	ow injury of	curred	
2 Accident 3 Suicide 4 Homicide	6 Could i	not be 28e, Place	of Injury - At ho ng, etc. (Specif	ome, farm, str				28f. Location (S City or Tow	itreet and N n, State)	umber or Rur	al Route Number,
27. Manner of Deal X Natural 2 \(\text{Accident} \) Accident 3 \(\text{Suicide} \) Suicide 4 \(\text{Homicide} \) 29a. Certifier (Check only one) 29b. Signature and	1 X Certifyin 2 Medical	ng Physician: To the Examiner: On the b and man	best of my kno asis of examina ner stated.	wledge, death tion and/or in	h occurred at the vestigation, in m	time, date a y opinion, de	nd place, a ath occurre	and due to the ded at the time, d	ause(s) and date and pla	d manner as s ice, and due t	stated. o the cause(s)
29b. Signature and	title of certifie	r			29c. Lice	nse number		2	29d. Date si	ned (Month,	Day, Year)
1	Sand	1			D42	014			5/23/	06	
30. Name and add	ress of person	who completed caus	se of death (Item	23a) (Type,					1-11		
SURINDER 31. Date filed (Mo.	oth, Day, Year)	32. F	egistrar's Signa	ture		CARE S	YSTEM	I, PERRY	POIN	T, MD	21902
	MAY 2	5 2006	CARAGES S	B. A.	DENELS						

			For State Registrar	(State of	Maryla				lealth and Death	Mental H	lygiene Reg. No	La U U L	165	560
	- M		Decedent's Name (First, A	fiddle, Last)							2. Date of	Death		3. Time of	Death
	Physici /Medic		Charles		Jose	eph		Soist	man		MAY	23	200	173	O M
	Examin		4a. Facility Name (If not instit	H0591	Ital			100	21+11	more more		B	County of De	more(yti'
	- Funeral - Director		5. Social Security Number 216–18–0106		4 2□F	7. Age (In yr.	s. last birthday	Month	er 1 Year s Days	If Under 24 Hr Hours Mir	n. (Month,	Birth Day, Year) 13 , 1		irthplace (State of Country) MD	r Foreigh
	and w		Usual Residence of Deceder 10a. State 10b. Co			10c. (City, Town or L	ocation.						10d. Inside Ci	ity Limits
	Many -1 sh	ţ	MD Balı	imore			Halet:	horne	1					1 🗆 Yes	2 X No
	death with the Maryland me 23a or 28a-f show Livest by neillfied at	Director	10e. Street and Number				110110		ip Code			10g. Cit	izen of What (Country?	
	th will		1245 Oakland	Terrac	e Road	1		2	1227			U.S	.A.		
	r dea	Funeral	11. Marital Status		. Was Deced	ces?	U.S. 13.	Was Dec	edent of h	Hispanic Origin? (an, Mexican, Pue	Specify Yes or	No-	14. Race - An Black, Wh	nerican Indian,	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ 3 🛣 Widowed 4 ☐ Divo	1	1 Yes, Give	9			2 X No					White	
옥	72 hours after death with the Marylar "naturel", or Iteme 23s or 28s-1 show tolical Expanding Count by notified at			edent's Educa	Year or Da	105.	16a. Dece	edent's Us	ual Occur	pation		16b. K	nd of Busines	s/industry	
215	hin 72 an 'na Mariji	plet	(Specify only h Elementary/Secondary (0-		College (1-	40r 5+\	(Give	s kind of w		during most of w	orking			a modelity	
21	er tha	Completed	9		- Conogo (Sel	lf En	ploy	ed		Mea	t Pack	ing	
pu	be file d oth event	Be	17. Father's Name (First, Mic							18. Mother's Na	ame (First, Midd	ile, Maiden	Sumame)		
Maryland 21 <u>2</u> 15-0036	d Men d Men narke	L P	Charles Jose				405 14		(2)		lyn Rev				
. ✓a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 le marked other than "naturel", or Iteme 23a or 28a-1 shov any Injury or other traumatic event, the Madical Examination to other traumatic event.		Mrs. Rita Mit			- h +				and Number or F					,
a Se	Heal Heal Hem		20a. Method of Disposition			20b.	Place of Disp cemetery, cre	osition (A	ame of	Terrace	D		orpe, I		
OE	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Qahe		noval from S	nate	_{сетекегу, сге} hesapea			1 5	26, 006	St	evenev.	ille, MD	1
$accentering} \mathcal{A}ccentering$	mit. I partm cortai / Injui		21. Signature of Fring al Ser			4.	2			ess of Facility S					
Z m	Deparent Dep		> Et fut			140				Avenue S					
2	And on the w		23a. Part1. Enter he diseas shock, or heart failure.	e, or complica List only one	tions that ca cause on ea	used the de ich line.	ath. Do not en	ter the m	ode of dyir	ng, such as cardia	ac or respiratory	arrest,		Approximate Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	a.	M	reta	state	10	10	ing C	ance	V		9 mset and to	
	/Medical Examiner		resulting in death)		Due to (c	or as a conse	equence of):			9					
ů.		-	Sequentially list conditions,	b	Due to (o	or as a conse	equence of):								
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
2.	be executed ician and burial-transit		resulting in death) Last	С	Due to (o	or as a conse	equence of):								
)Q 8760	cate be execu ohysician and the burial-trar	dlcal		d											
2 9		Med	IF FEMALE:												
+ Y	that the death certific ed by the ettending p detached for use as	Physiclan/Me	23b. Was decedent pregnan in the past 12 months?	t 23c		th 2 ☐ Fe	tal death 3[pregnancy	у		4	23d. Date of de Month	,	r ear
0.0	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 □ Pregna 9 □ Unknov	int at time of wn	death 5	Other (specify)					,	
. O.	The law requires that the death certifi vie has been signed by the ettending to bage 2 should be detached for use as		Part II. Dther significant cor	ditions contr	buting to dea	ath but not re	sulting in the u	underlying	cause giv	en in Part I.	23e. Die	d tobacco u	se contribute	to the cause of d	eath?
Z Š	quires n sign	ed by									a	Yes 2]No 3 ☐ F	robably 4 🗆	Jnknown
00	aw requir 1s been s 2 should	Completed									24a. W	as an	24b. Were a	utopsy findings a	available
R	The la	E O									au pe 1 ☐ Yes	topsy formed?	prior to	utopsy findings a completion of ca s 2 No	ause of
ita	ician: The lav certificete has rector, page 2	BeC	25. Was case referred to me examiner?	dical						26. Place of De	ath (Check onl		1310	3 2 110	
>	Physic this ce al dire	To	1 ☐ Yes 2 No				☐ ER/Outpatie	nt 3 🗆 [4 🗆 Nuising	Home 5□Re	sidence (0ther (Sp	ecify)	
o u c	ding Physician: The h. h. After this certificete ha funeral director, page	lon:	27. Manner of Death 1X Natural 5 ☐ Pe		28a. Date of (Month	i Injury n, Day Year)	28b. Time o Injury		28c. Injur Wor		28d. Describ	e how injur	y occurred		
ک – Division of Vital Record	death death ctor: / the f	cat	3 ☐ Suicide 6 ☐ Co	restigation ould not be	28a Place	of Injuny - At	home, farm, st	M .		Yes 2 □ No	28f Location	(Stroot on	d Alumbas as F	Pural Route Num	has
Div	after after Direct	Certification:	4 🗌 Homicide de	termined	building	g, etc. (Spec	cify)	reet, racti	iry, omce		City or 7	own, State,)	drai Houle Num	oer,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier 1 Cert (Check only 2 Med	ifying Physic ical Examine	ian: To the b	sis of examir	nowledge, deal nation and/or in	th occurre	d at the tir in, in my o	me, date and plac ppinion, death occ	e, and due to the	e cause(s) e, date and	and manner a place, and du	s stated. e to the cause(s)
	To the within To the complex c	Me	29b. Signature and title of ce	rtifier				2	9c. Licens	e number		29d. Dat	signed (Mon	th, Day, Year)	
			K ()	N	$ \wedge $				D3	Sasi	1	5-)3-	06	
	10		30. Name and address of per	son who com	pleted cause	of death (Ite	em 23a) (Type,		1	0 1)			0.0	
_	1		Curoler	Mar	- W	290	D>-	Co	tun	Mue 3	DIVIT	MY	791	227	
3	Sta Registr		31. Date filed (Month, Day, Y		32 Re	gistrar's Sigr	nature And	all I							

1. Decedent's Name (First, Middle, Last) Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) HAROLD SOLOMON 4. Facility Name (If not institution, give street and number) 4. Facility Name (If not institution, give street and number)	Day Year 22, 2006 4c. County of Death
Medical Ab City Town or Location of Oceth	001 200
Examiner 4a. Facility Name (it not institution, give street and number) 4b. City, Town, or Escation of Death Singi Hospital Of Buttimore Buttimore City	N/A
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Bir	
	71919 MD
5 \$ 10a State 10h County 10c City Town or Location	10d. Inside City Limits
10a. State 10b. County 10c. City, Town or Location MD N/A BALTIMORE 10a. Street and Number 10f. Zip Code	1 M Yes 2 □ No
MD N/A BALTIMORE 106. Street and Number 107. Zip Code	10g. Citizen of What Country?
10e. Street and Number 7111 PARK HEIGHTS AVENUE #811 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Not If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	USA
7111 PARK HEIGHTS AVENUE #811 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 18. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	b- 14. Race - American Indian, Black, White, etc.
To a. State 10b. County 10c. City, Town or Location 10d. Zip Code 10d.	Specify: WHITE
3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life DN NOT use partial)	16b. Kind of Business/Industry
(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ATTORNEY	1.011
Elementary/Secondary (0-12) 5+ College (1-4or 5+) ATTORNEY 18. Mother's Name (First, Middle, Last) DALL PALL SOL OMON FETTIFE	LAW
MD N/A BALTIMORE 106. Street and Number 7111 PARK HEIGHTS AVENUE #811 21215 109. Street and Number 7111 PARK HEIGHTS AVENUE #811 21215 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1. Mare forces? 1. Ma	BROZER
19a. Informant's Name/Relationship (Type, Print) MAXINE SOLOMON / WIFE 19b. Mailing Address (Street and Number or Rural Route Numb 7111 PARK HEIGHTS AVE. #811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	
MAXINE SOLOMON / WIFE 7111 PARK HEIGHTS AVE. #811 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Significant of Funeral Service Lice service 8900 REISTERSTOWN ROAD -	20c. Location - City or Town, State
1 Ma Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	WOODLAWN, MD
20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Singleton of Funeral Service Lice seef 22. Name and Address of Facility SOL LEVI	NSON & BROS., INC.
	PIKESVILLE, MD 21208
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	4 3045
Description of the past 12 months? 1 FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 Yes 2 No 9 Unknown 1 Female: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	tobacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 ☆ Ûnknown
The second of second of the se	
The page 2 should be the first page 2 should be the first page 3 should be the first page 4 should be	psy prior to completion of cause of death?
Part of the control o	one)
On the control of the	
28d. Describe 30 Activative investigation 4 Activative investigation 4 Activative investigation 5 Activative investigation 5 Activative investigation 6 Activative investigation 7 Activative investigation 8 Activative investigation 9 Activative investigation 1	how injury occurred
Accident investigation 24a. Was a surposed by the property of the policy of the polic	Street and Number or Rural Route Number, wn, State)
See 2 29a. Certifier 1	cause(s) and manner as stated. date and place, and due to the cause(s)
one) and manner stated. 29c. License number	29d. Date signed (Month, Day, Year)
Para End Char	May 22 2006
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1111 12, 2006
130. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uchengs E. Okagbul. MD Sings Hospital of Baltimore	~
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar MAY 2 5 2006	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ROSE $\mathsf{SPERZEL}$ May 23. 2006 2:00 A MARIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BRIGHTON GARDENS OF TOWSON Baltimore Baltimore County If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 ☐ F Yrs. 102 Director 212-09-0561 Dec 26, 1903 Maryland Usuel Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow Depertment of Health and Mental Hygiene important; or Items 23a or 28a-1 ehov important: if Item 27 ie marked other then "natural", or Items 23a or 28a-1 ehov eny jujury or other treumatic event. In Medical Examinar must be notified at ance. 1 ☐ Yes 2 No Directo Maryland | Baltimore County Baltimore 10e. Street and Number 10g, Citizen of What Country? Funeral 6451 North Charles Street Peges 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No II Yes, Give Year or Dates: 1 ☐ Yes 2 1 No Specify. Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beautician Hair Care & Hygiene 2 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph A. Sperzel Mary Gertrude Goodhues ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dorothy Linder (Pers. Rep) 3606 My Lady's View, Monkton, Maryland 21111 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₽ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 5/26/2006 Baltimore, Maryland 21. Significant Fundal Service Libensee

Martin D. Lawson 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson

6500 York Road, Baltimore, Maryland

21212

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest, interval Between Onset and Death

Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Physician /Medical Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last physicien ar s the burial-t Due to (or as a consequence of): Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 X No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 1 Yes To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined efter 4 Homicide Medical 29a. Certifier to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours e To the Funeral C completely filled

Baltimore, Maryland 21215-0036

Chri Win Mym! Khin W. Myint, M.D. State

29b. Signature and title of certifier

29c. License number 20055301 29d. Date signed (Month, Day, Year) 05 23 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 North Charles Street, Towson, Maryland 21204 31. Date liled (Month, Day, Year) 32. Registrar's Signature

MAY 2 5 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** May 21 2006 4:00a.m. John Melvin Schenning /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 3802 Fait Avenue Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1√2 M 2□ F Months Days Hours 87 1919 Maryland 220-07-3666 April 16, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or Itams 23a or 28a-4 ehror any injury or othar traumatic avant, the Mention I. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 TYes 2 □ No Maryland Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 U.S.A. 3802 Fait Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. I∏Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No White Specify þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Building Inspector 12th grade Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Loeffler Albert Schenning 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3802 Fait Avenue, Baltimore, MD 21224 Virginia Schenning/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Kurial 2 □ Cremation 3 □ Removal from State 05-25-06 Baltimore, MD Sacred Heart of Jesus Donation 5 Other (Specify) 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. ure of Funeral Service Licensee 21. Sign 4226 Eastern Avenue, Baltimore, MD mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death 23a. Part Enter the disease of cor shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Physician 2400 /Medical Due to (or as) consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in the cause (Diseas Due to (or as a consequence of): Examiner the attending physician and Completed by Physician/Medical Year death? Unknown available ause of Be Medical Certification; To

Hoapital or Attanding Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After after death. filled in by

ause (Disease or injury nat initiated events esulting in death) Last	CDue to (or as a conseq	uence of):			
FFEMALE: (3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	I death 3 ☐ Ectopic			23d. Date of delivery Month Day Year
11. Other significant conditions co	entributing to death but not res	sulting in the underlying	g cause given in Part I.	23e. Did tobacco	use contribute to the cause of deatl
				24a. Was an autopsy performed?	
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing I	Home 5 Residence	6 □Other (Specify)
7. Manner of wath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Tyes 2 No	28. Describe how inj	ury occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci		ory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier Check only one) Certifying Phi	ysician: To the best of my known iner: On the basis of examination and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and plac ion, in my opinion, death occ	e, and due to the cause(urred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)

State

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within 24 hours a To tha Funaral [

To the

completely

trancis mairis 31. Date filed (Month, Day, Year)

29b. Signature and little of celtifier

29d. Date signed (Month, Day, Year,

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar

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25. Was case referred to medical examiner? 1 Yes 2 No	COL	s beer shou	olete	Hodgkins Dizyers			24b. Were aut	opsy findings available
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30. Name and adding is of person who completed cause of death (Item 23a) (Type, Print)		the Hosp in 24 hot he Fune pletely fil	edical	(Check only 2 Medical Examiner: On the basis of examination and/or	investigation, in my opinion, death occurr	ed at the time, dat	e and place, and due t	to the cause(s)
1) I was a superior of the state of the stat		Mith To I	Σ				•	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signiture		5		2 1 2 5 1 11/10 1 11/10	- horrent Pankhian	Colum	am pid	21044
				31. Date filed (Month, Day, Year) MAY 2 5 2006	rente			

			State Amend Item	State of Maryl #23b&c Per	and / Depa Phy G857	rtment of Ho tificate of D	ealth and I Death	Mental Hyg	iene _{og. No.} 2008	16565
			Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death
	Physicia		Horahan A.	Tomas	Sn,			Month	Day Year	9-60 PM
)	/Medic Examin		4a. Facility Neme (If not institution, give s	reet and number)		4b. City, Town, or	Location of Death	l	4c. County of Dea	ith
	LAdiiiii	C1	1-2-6, 1007	H. ch. * 6	1	and	- Mitter 2	110	13214	4 2 7
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year	il Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		231-36-0563	M 2□F 7/4	Yrs.	Months Days	Hours Min.	(Month, Day, 04/30/19		ountry) Cginia
			Usual Residence of Decedent						J2 1 V 1 1	SINIU
	ylan		10a. State 10b. County	100	. City, Town or Lo					10d. Inside City Limits
	Mar I	ţo	Maryland		Ba1t	imore				1X Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	h wit	a D	3207 Burleith Aven	ue		21	215		U.S.A.	
	dea	Funeral	11. Marital Status	Was Decedent Ever Armed Forces?	in U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Si	pecify Yes or No-	14. Race - Am Black, Whi	
9	after or its		1 Never Married 2 Married	1 ☐ Yes 21 No			Specify:	o rican, etc.)	Specify: B]	
සි	ours Tall,	δ	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		☐ Yes 2X No	эрөспу.		Specify: D	Lack
20	within 72 hours after death with the Maryland ene. then *natural', or iteme 23e or 28e-f ehow he Madicel Exeminer must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		(Give	ent's Usual Occupa	lurina most of wor	kina	16b. Kind of Business	√Industry
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2	Hygien Hygien other th	So	8		па					21011
힏	m == 0 =	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, I	Maiden Sumame)	
Maryland	2 should be filed and Mentat Hygi is marked other aumatic event,	2	Roosevelt Tanne	r			Annie M	lae Whitl	.ock	
ā	2 she and is m	1	19a. tnformant's Name/Relationship (Ty)						, City or Town, State,	
	and Balth n 27		Annie Mae Tanner /			a because the Committee Control of A land becomes	Avenue,		e, Marylan	
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ♣ Cremation 3 ☐ R	1	b. Place of Dispo cemetery, cren	sition (Name of natory or other place	9)	Date	20c. Location - City or	Town, State
Ĕ	Pag nent ant: h		4 Donation 5 Other (Specify)		etro Cre	matory In	05/24	/2006 B	altimore,	Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta important: If Item 27 is marked eny injury or other traumatic es		21. Signature of Funeral Service Liceose	0	22	. Name and Address	s of Facility The	Derrick	C. Jones	F/H, P.A.
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	/Medical		disease or condition resulting in death)	Due to (or as a con	nsequence of):	11002	Fin	1200		
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9	g phy as th	ed								
Вох	leath certific attending p I for use as	N	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pr					23d. Date of de	livery
m	death e atte d for	Physician/Me	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time		Ectopic pregnancy Other <i>(specify)</i>			Month	Day Year
P.0	that the ded by the detached	hys	9 Unknown	9□ Unknown						
	s that ned t	by P	Part II. Other significent conditions cor	tributing to death but no	t resulting in the ur	nderlying cause give	n in Part I.	23e. Did tot	oacco use contribute t	o the cause of death?
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Division	i Si te	Certification:	4 Homicide determined	building, etc. (Sp	pecify)	oot, lactory, office		City or Town		arai riodio ridinogr,
_	pite ours oral	S S	29a. Certifier 1 Cartifying Phys	ician: To the best of my	knowledne death	occurred at the tim	e, date and place	and due to the or	ausa(s) and manner -	hateta a
	Hos 24 h Fun stely	edicai	(Check only 2 Madical Examinations)	nar: On the basis of examined manner stated.	mination and/or inv	estigation, in my op	pinion, death occu	rred at the time, da	ate and place, and du	e to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Mon	th, Day, Year)
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	/		20 Name and add to a discount	mbleted cause of days	(Item 23a) /Tues	Print)	41/	4	may >1	7 700/
	h		30. Name and address of person who co	nipleted cause of death	(nem ∠oa) (Type,	r integ	1-1.	+1	1711	hery k
	-84	to	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature -	reld,	1-122/2)	13/	1-745	HALVER,
	Sta Registr		MAY 2 5 2006	Alger . A	X Good	الم	/			
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State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** PM Lillian Thompson 1753 MAY 22 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner N/A Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🗹 F Yrs 213-32-0088 84 Apr 3, 1922 Maryland **Director** Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "naturel", or Iteme 23a or 28a-f ehow eny injury or other traumatic event, Tra Medical Exacultor Inval be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 Yes 2 No Baltimore N/A Director Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 5454 Narcissus Avenue 21215 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specify: Black 3 □ KWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) Entertainment Industry **Bar Maid** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Robinson **Emery Stewart** 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5454 Narcissus Avenue Baltimore, Maryland 21215 Angela Brown Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 05/26/06 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Western Cemetery 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Priysician 8 days Ceresoral hadmorrhage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) P.O. | 1 ☐ Yes 2 ☐ No 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate has 2 1 No 1 Yes 1 Yes 2 1 No or Attending Physician: director. 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \((Specify) \) 1 Inpatient 1 ☐ Yes 2 ☑ Ño 2 ER/Outpatient 3 DOA Certification: To funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Natural 5 Pending s efter dec. 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours eft To the Funeral Di t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cyallagher mo AT2438946 MAY 22 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATHERINE GALLAGHER MD UMON MEMORIAL HOSPITAL, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 33461 Registrar 2 5 2006

			For Stete Registrar	State of Marylan		artment of F			giene 005	16567			
7	Dhualai		1. Decedent's Name (First, Middle, Last	1)				2. Date of De Month	ath Day Year	3. Time of Death			
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	and *	}	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits			
	Aaryli • ho	ō								1 Yes 2 No			
	28a-1	Director	MD Baltmor	Da Da	Himor	10f. Zip Code			10g. Citizen of What Co	untov?			
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	eeth	Funeral I	590 Leewood 11. Marital Status	12. Was Decedent Ever in U	S. 13.	Was Decedent of H		Specify Yes or No	- 14. Race - Ame	rican Indian.			
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21215-0036	be filed within 72 hours after deeth with the Maryland nat Hygiene. ed other than "nature!, or iteme 23a or 28a-f ehow event, the Medical Exam. are must be notified at	Completed	15. Decedeni's Ed		16a. Dece	dent's Usual Occup	pation	4.5	16b. Kind of Business/	ndustry			
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Maryland	s 1 and 2 should Health and Men tem 27 ie marke other traumatic		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailir	ng Address (Street	and Number or R	urai Route Numb	er, City or Town, State, 2	ip Code)			
	and all h		Upshur Webb	Sh,	5901	Leevotod	Ave; Bal	timore,	MD21228				
Baltimore,	es 1 an of Heal if Item 2 or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		Place of Dispo	sition (Name of matory or other place		Date	20c. Location - City or	Town, State			
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ati	permit. Pag Depertment Important: I eny tnjury o		21. Signature of Funeral Service Licens	see	22	Name and Addre	ss of Facility						
m	Deperiment of the poor of the		Froze, MD	21329									
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. 8	a dea ne ett ed fo	sici	in line past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnancy Other (specify)	<u> </u>		Month Day Year				
P.0	at the de by the e	h	9 Unknown										
	igned i	by	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause giv	ren in Part I.		obacco use coniribule lo				
ord	w require been si should i	ed						1 📑	Yes 2 No 3 Pr	bably 4 Onknown			
Records,	e law r has be	Completed						24a. Was		topsy findings available ompletion of			
Ě	Physician: The this certificate had director, page	E						perfo	rmed?/ death?	21 No			
Vital	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	***			26. Place of De	ath Check only	-				
~	Physic this ce al dire	2	1 Yes 2 No	Hospital: 1 Impatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing l	Home 5 ☐ Resi	dence 6 ☐Other (Spec	city)			
n of			27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Wor	y at rk?	28d. Describe	how injury occurred				
Division	Attending or death. ector: After by the fune	atic	2 Accident investigation		. ,		Yes 2 □ No						
<u> <u> </u></u>	r Att	#	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	eet, factory, office		28f. Location (Street and Number or Ru wn, State)	ral Route Number,			
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Certification;											
	houn une une une une	cai	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina	w/edge, deat	t occurred at the tit	me, date and plan	e, and due to the urred at the time.	date and place, and due	to the cause(s)			
	the Pain 24 the F	Medical	one)	and manner stated.						``			
	To To	2	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Montl				
	d		Degallagher ms			AT24	38946		MAY 22 20	106			
6	21		30. Name and address of person who o										
	U		CATHERINE GALLAGH	- /		RIAL HOSP	TAL, MI)					
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	*							
7	Regist	rar	MAY 2 5 2006	Blown B	Goode	15							

		1	For State Registrar	State of	Marylan		artment of H		nd Ment		ene 20	06	16568
	F-100-4	_	Decedent's Name (First, Middle	e, Last)						ate of Death	Day	Year	3. Time of Death
	Physicia /Medic		AUDREY	MAE WRIG	HT				Ma		8 200	06	2:05 p ^M
	Examin	_	4a. Facility Name (If not institution	n, give street and num	ber)		4b. City, Town, or	r Location of	f Death		4c. County o	of Death	
			108 BOWLEYS		RD.	lant hidhdau	BALTI If Under 1 Year	MORE	A Hrs on	ate of Birth	BALT		Lace (State or Foreign
2	Funeral Director		5. Social Security Number 215-32-6083	6. Sex 7		9 Yrs.	Months Days	Hours	Min. (A	Nonth, Day, Y	'ear)	Coun	try) YLAND
	*	-	Usual Residence of Decedent						DE			7 12 11 1	
	ylanc how		10a. State 10b. County		10c. City	y, Town or Lo	cation					11	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	e Ma	cto	MARYLAND BALT	IMORE CO			HASE						
	er 2	Funeral Directo	10e. Street and Number				10f. Zip Code			10g	J. Citizen of W		try?
	s 23s	ral	108 BOWLEY'S	QUARTERS RI		C 12 1		21220	in? (Specify)	Yes or No-	U.S.		an Indian,
	Item de	ın.	11. Marital Status1 ☐ Never Married 2 ☐ Married	Armed Ford	ces? 2 MNo		Was Decedent of H f Yes, specify Cuba	an, Mexican	, Puerto Ricar	n, etc.)		, White,	
920	urs at	þ	3 ☐ Widowed 4 ☐ Divorced		•		1□Yes 2⊠Xio	Specify:			Specify:	BLA	CK
Maryland 21215-0036	y within 72 hours after death with the Maryland jane. 'Than "natural', or Items 23a or 28a-f ahow Ite Mejical Exa⊤inet must be notified at	Completed	15. Deceden	t's Education st grade completed)		16a. Dece	dent's Usuaf Occup	ation during most	of working	16	b. Kind of Bus	siness/inc	dustry
21	within and and and and and and and and and an	nple	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use retired	d)	3		A C DUD	T T (7)	MIONC
21	e filed w Il Hygier other th		12th grade 17. Father's Name (First, Middle,	(351)			SELECTER	18 Mothe	r's Name (Firs		A G PUB		TIONS
and	Q 52 50 9	Be	, , , , , ,	,					NRIETTA			•/	
Ž	should be ind Mental s marked umatic ev	2	RAYMOND K. Bi			19b. Mailir	ng Address (Street					State, Zip	Code)
∑	1d 2		Wayne Wright/			108	Bowley's	Ouar	ters Ro	a., Cha	ase, Ma	ryla	nd 21220
d)	s 1 ar f Hea itam other		20a. Method of Disposition		0	lace of Dispo	esition (Name of matory or other place		Date		c. Location - 0		
E C	Page tent o nt: If ry or	١.	1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		tate	-	STAR BAP		05-25-0	06 (CHASE,	MARY	LAND
Baltimore,	permit. Pages Department of H Important: If its any injury or of once.		21. Signatur of Funeral Service Licensee 22. Name and Address of Facility WM C. BROWN COMMUNITY FUNERAL HOME-HARFORD, P. I										
<u>m</u>			321 S PHILADELPHIA BLVD., ABERDEEN, MD 2100										ID 21001
67			23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications that ca only one cause on ea	used the deat ich line.	h. Do not ent	er the mode of dyir	ng, such as	cardiac or resp	piratory arres	t,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition										
	/Medical Examiner		resulting in death)		or as a conseq RINA		ARTE	MH	10	CISTAL	_		
A		-	Sequentially list conditions,	b. Due to (c	/ / / - / /	101		3 000					
7	ned I	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Noli	1001.								
Ć	te be executed ysician and e burial-transit	Еха	resulting in death) Last	Due to (c	or as a conseq	uence of):							
8760,	Attending Physician: The law requires that the death certificate be executed rideath. rideath. ector: Atter this certificate has been signed by the attending physician and better this rector, page 2 should be detached for use as the burial-transit.	cal		d									
99	ndifica ng ph		IF FEMALE: N	1		<u>-</u>							
Вох	eath certific attending p	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes Daw 23c. If yes, outcome of pregnancy 1 Daw Daw 23c. If yes, outcome of pregnancy 1 Daw Daw 23c. If yes, outcome of pregnancy 1 Daw Daw 23c. If yes, outcome of pregnancy 1 Daw Daw 23c. If yes, outcome of pregnancy 1 Daw Daw 23c. If yes, outcome of pregnancy 1 Daw Daw 23c. If yes, outcome of pregnancy 1 Daw Daw 23c. If yes, outcome of pregnancy 1 Daw Daw 23c. If yes, outcome of pregnancy 1 Daw Daw 23c. If yes, outcome of pregnancy 1 Daw Daw 23c. If yes, outcome of pregnancy 1 Daw Daw 23c. If yes, outcome of pregnancy 1 Daw Daw 23c. If yes, outcome of pregnancy 1 Daw Daw 23c. If yes, outcome of pregnancy 23										nry Day Year
0.	at the dea by the a	ysic											
٥.	res that th igned by be detac		Part II. Other significant conditi	ons contributing to de	ath but not res	ulting in the u	nderlying cause giv	en in Part f.		23e. Did toba	cco use contri	bute to th	ne cause of death?
ds,	uires sign d be	d by	COPD	•						1 🗆 Yes	EDNO.	3 ☐ Prob	ably 4 □Unknown
Vital Records,	w require been si should I	Completed							2	24a. Was an	24b. W	/ere auto	psy findings available
Re	The lav	mo								autopsy performe Yes 12 ☐	ed? de	rior to cor eath? □ Yes	npletion of cause of
ita	sician: Th certificate rector, pag	0	25. Was case referred to medica	if				26. Place	of Death (Ch				
of <	nysici nis ce direc	To B	examiner?	Hospital: 1 🗆 Ir	npatient 2	ER/Outpatie		4 🗆 140	rsing Home	5 Residen	ce 6 □Othe	r (Specify	<i>ı</i>)
_ _	ding Phy h. After thi funeral o		27. Manner of Death Natural 5 ☐ Pendi	28a. Date o (Monti	f Injury h, Day Year)	28b. Time o Injury	Wor			Describe how	injury occurre	ed	
Sio	ttendi death. ctor: A the fu	cat	2 Accident invest	not be	of Joiney - At h	omo farm et	M 1 □	Yes 2□I		ocation (Stre	et and Numbe	or Rura	l Route Number,
Division	after d Direc J in by	Certification:	4 Homicide determ		ig, etc. (Specif		eet, ractory, office		201. 6	City or Town,	State)	, o, ribra	, righte values,
_	To the Hospital or Attent within 24 hours after deati To the Funeral Director: completely filled in by the		29a. Certifier Certifyi	ng Physician: To the	best of my kno	wiedge, deat	h occurred at the til	me, date an	d place, and c	lue to the cau	rse(s) and mar	nner as si	ated.
	To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medical one)	Examiner: On the ba and mann		ition and/or in	vestigation, in my o	opinion, dea	th occurred at	the time, dat	e and place, a	nd due to	the cause(s)
	To th Withir To th comp	×	29b. Signature and title of certific	er , ,	A		29c. Licens	se number			d. Date signed		A.
	7		Satar 18	witch	dam	. W) 1) -1	190	7 >	-	2-5.	2 - 0	5 G
	1/		30. Name and address of person	UARN	1, 100	13	-24	UES	Aco 1.	Jve.	2123	7	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year	A	egistrar's Signa	k Á	rade						
2.	, icalst	1 A	MAY 2	71116	BHILL J	AJ. AS	ABTEC						

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryland	d / Depa	artment of H	lealth ar Death	nd Mer		jiene2	106	16	569
-35	P Photosis		1. Decedent's Name (First, Middle, Las			_		2.	Date of Dea Month	th Day	Year	3. Time of	Death
	Physici Medic	46	VERMON.	H. WEEM	5 2	R.		M	IAY		006	10	рМ
dign	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of [Death		4c. Count	y of Death	1	
			CRESCENT CITY CENTER			RIVERDALE				PRINCE			
в	Funeral		5. Social Security Number 6. Se	DM 2DF	a <i>st birthd</i> ay) Yrs.	Months Days	If Under 24 Hours	Min.	Date of Birth (Month, Day	, Year)	Cou	place (State o	
	Director		214-42-3627 Usual Residence of Decedent	-X** 62	113.			AL	JG. 31,	1943	DIST	RICT OF	COLUMBI
	land		10a. State 10b. County	10c. City	r, Town or Lo	ocation						10d. Inside Ci	ity Limits
	Mary f sh	Į	MARYLAND ANNE ARUN	DAI 1.4	UREL							1 ☐ Yes	2 🗌 No
	28a	Director	10e. Street and Number		IOILEE	10f. Zip Code			1	0g. Citizen of	What Cou	untry?	
	3a o	D	3605 LAUREL VIEW COU	RT		20724				U.S.A.			
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show than "Madical Examinar must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin	n? (Specify	Yes or No-	14. Ra		ican Indian,	
9	or Ita	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	1		Specify:	rueno nic	an, etc.)		ick, White fy: BL		
9	ral',	d by	3 ☐ Widowed 4 🖾 Divorced	Year or Dates:		10163 20,40	эреспу.			Зресі	iy. DLi		
21215-0036	72 h 'natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most o	of working		16b. Kind of B	Business/I	ndustry	
2	han ne.	m	Elementary/Secondary (0-12)	College (1-4or 5+)	CUSTOD		1)			EDERAL (UNEDVI	MENIT	
2	filed v Hygie other t		17. Father's Name (First, Middle, Last)		C0310D	IAN	19 Mother's	Name /F		Maiden Suma		TENI	
and	d od o	Be	HERBERT WEEMS				MILDRE			marcon coma	110)		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene Item 27 is marked other than "natural", or Itams 23a or 28a-f show Item 27 is marked other than "natural", or Itams Itamolified at	٩	19a. Informant's Name/Relationship (7	Tugo Print)	10h Mailie	ng Address (Street a				City of Tour	State 7	in Codel	
<u>s</u>	nd 2 salth an 27 is a		DAVID WEEMS/SON	, yp6, 171111)		AUREL VIEW						p 000 0 /	
	1 and Health em 27		20a, Method of Disposition	20b. P	lace of Dispo	sition (Name of		Date		20c. Location		Town, State	
jo	Pages nent of int: If It		1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		matory or other place	1	00/000					
Baltimore,	permit. Pages 1 a Department of Hea Important: If Item any injury or othe once.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	,		TIONAL CEM. 2. Name and Addres		20/200	16 L	AUREL, M	ARYLA	ND	
Ba	permit. Departm Importa any inju		Mana	5 /1 M.	F	LECK FUNERA	AL HOME	045 14	UDEL WA	DVI AND O	0707		
	- 6-30		23a. Part1. Enter the disease, or comp	plications that caused the death		601 SANDY S					0/0/	Approximat	
760, گ	The law requires that the death certificate be executed Te has been signed by the attending physician and Te has been signed by the attending physician and Te has been signed by the attending physician and Te has been signed by the attending physician and Te has been signed by the attending physician and attendi	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of): uence of):	R						Onset and I	Jeath
89	tificat ng phy as th												
P.O. Box	at the death certifica by the attending phi tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3[Ectopic pregnancy Other (specify)					ate of deliv		Year
	res that iigned b be deta	by Pł	Part II. Other significant conditions of		23e. Did to	tobacco use contribute to the cause of death?							
ğ	quire in sig uld b	pe p	PNEUMONIA						1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown				
၀	sw requir s been si s should I	Completed							24a. Was a		Were aut	opsy findings	available
æ	The lay te has age 2	E O							autops perform		death?	ompletion of c	ause of
a		a	25. Was case reterred to medical				26. Place of	f Death (C	heck only on		103	20110	
>	ysici is cer direc	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Othe				ence 6 □Ot	her (Speci	ify)	
0	Attending Physician: r death. sctor: After this certificaby the funeral director, I		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		y at			ow injury occu			
Ö	andir ath. or: Af	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	ו			Yes 2□No						
Division of Vital Records,	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	 28e. Place of Injury - At he building, etc. (Specify 	me, farm, sti	reet, factory, office		28f.	Location (Si City or Town	treet and Num n, State)	ber or Rur	al Route Num	ber,
	rs afte ral Dir	Cer											
	To the Nospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 ☑ Certifying Ph (Check only 2 ☐ Medical Exan one)	ysician: To the best of my kno- niner: On the basis of examina- and manner stated.	wledge, deat tion and/or in	h occurred at the tim vestigation, in my of	ne, date and p pinion, death	place, and occurred a	due to the cat the time, d	ause(s) and m ate and place	anner as and due	stated. to the cause(s	,)
	To To E	Σ	29b. Signature and title of certifier	100 MA		29c. License	e number		2	9d. Date sign	8.		
			1080	19		D482	13			120	18	2006	
	5		30. Name and address of person who NEELAW, ASHAI, MD	4410 79th AVENUE	LANDOV	Print) ER HILLS M	ID 20784						
	Sta Regista		31. Date filed (Month, Day, Year) MAY 2 5 2000	32. Registrar's Signa	ture Loca	les .							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#,20b,perfff,(855,5/25/06 TT)
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** -10 2006 PVPS /Medical 4c. County of Death et and number) 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give sty Examiner KIUZA If Under 1 Months 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) (State or Foreign 5. Social Security Number 6. Sex 7. Age (In ÿrs. last birthday) **Funeral** Min. 22 Days Hours 1 □ M 2 104 MARYLAND Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State or 28e-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 16 Completed by Funeral Director Bei 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 210 or Items 23a reictori 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. 11. Marital Status Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or itemany injury or other traumatic event. 1 Yes 2 Ao If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: W 1 ☐ Yes 2 🗓 🗝 6 Maryland 21215-0036 Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) nve 18. Mother's Name (Pirst, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be hle 2 onla 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/ elationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 25 20c. Location - City or Town, State 20a. Method of Disposition 4 ☐ Donation 5 ☐ Other (Specify) Evano Funeral Chapet-Belfit 5 Forest Hill 200 22. Name an Address of Facility 21. Signature of Funeral Service Licensee OREST HILL MD 21050: EVANS FUNCHALCHAPEL-BELAIR. BNEWPORT IX Sural Mell e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760. use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 mor for 4☐ Pregnant at time of death 5 Other (specify) P.0. the be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? After 5 Pending investigation 1: Natural 1 🗌 Yes 2 🗌 No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed

everly W.

an

32. Agistrar's Signature

Year)

5

06-03347 Clif

Please Type or Print in Black Indelible lak

ifton Wilson		State of Maryland / Department of Health and Mental Hygiene									
			rtificate of Death	Reg. No.	0 100						
Physici		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death						
edical Exami	iner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	May 17, 2006	2258 hrs						
}		Franklin Square Hospital	Rosedale	4c. County of Death Baltimore Cou	nty						
Funerai		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday) If Under 1 Year If Under 24H		,						
Director		214-86-8976 1×m 20F 39	Yrs. Months Days Hours M	lin. Foreig	n mintry) MN						
		Usual Residence of Decedent		17-3 10/1166	11.17						
w au		10a. State 10b. County 10c. City	v, Town or Location		10d Inside City Limits						
yland I-f sho	tor	10e. Street and Number	x 14 more		1 Yes 2 No						
e Mar or 28;)ire	-1/1 (A) :1 (D)	10f. Zip Code	10g. Citizen of What Coun	try?						
with the s 23a e noti	Funeral Director	11. Marital Status 12. Was Decedent Ever in U	J.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - Americ	ean Indian Black						
death r item	nne	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puer		an maan, black,						
after	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	Specify: B	ack						
215-0036 be filed within 72 hours after death with the Maryland mill Hygies discher than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind o during most of working life. DO NOT use re		ndustry						
136 hin 72 e than '	ple	Elementary/Secondary (0-12) College (1-4 or 5+)	Carpenton	Home Imp	2 . 2 . 2 . 15						
5-00 ed with tygien other he Me	Completed	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname)	18 Jephen 13						
21215-0036 uld be filed within 7 Mental Hygiene marked other than ic event, the Medica	Be	Sylvester Wilson Jr	Del	ores Clark							
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Manal Hygiene fant: If licen 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examing: must be notified at once.	욘	19a. Infórmant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number of		Zip Code)						
Baltimore, MD sernit Pages 1 and 2 sho Department of Health and Important: If item 27 is		20a. Method of Disposition 20b.	Place of Disposition (Name of cemetery,	Date 20c. Location - City or 1	21313						
Ore ges 1 at of H		1 Burial 2 Cremation 3 Removal from State	crematory or other place)	Date 200. Location - City of	OOT						
Baltimo permit Page: Department o Important: I		4 Donation 5 Other Specify:	22. Name and Address of Facility	in 27, 2000 Innda (1C.	ITID						
Ba Perit Depi		Rinald a Braymon	108 W North Ave 2	Ronald Grayson 17	un. Home						
Physician		23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	n. Do not enter the mode of dying, such as cardiac	correspiratory arrest, shock, or heart	Approximate Interval						
/Medical Examiner		Immediate Cause (Final disease a. Hypertensive at	herosclerotic cardiovascular	disease	Between Onset and Death						
1		or condition resulting in death) Due to (or as a consequence of	of):								
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	of):								
	Examiner	C cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last events resulting in death). Last									
ecuted and transit	I Ex	events resulting in death) Last Due to (or as a consequence of d.	51).								
O, the executed sician and ourial - transi	dical	XXUNPENDED AMENDED item#23a	1,27,perME,g857,7/26/06 TT								
68760 certificate h nding physi		IF FEMALE: 23c. If yes, outcome of preg 23b. Was decedent pregnant in the		23d. Date of delivery							
c 68 certif	cian	past 12 months? 1 Live birth 4 Pregnant at time of de	2 Fetal death 3 Ectopic pregreath 5 Other (Specify)	nancy Month Da	ay Year						
Box e death of the atten	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)								
cords, P.O. Box 68760 law requires that the death certificate has been signed by the attending phystylouid be detached for use as the best should be detached for use as the best should be detached for use as the best properties.	by PI	Part II. Other significant conditions contributing to death but not re	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the							
S, P quires the an signe alld be d				1 Yes 2 No 3 Proba							
ord aw rec has bee	ple			autopsy prior to co	opsy findings available impletion of cause of						
Rec The ficate	Completed			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No						
Vital I ysician: his certifi director,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	26 Place of Death (Check ER/Outpatient 3 DOA Other Nurs								
n of Vital Recting Physician: The After this certificate funeral director, page	-: To	27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	ing Home 5 Residence 6 Other: 28d. Describe how injury occurred							
On cendin sath.	tion	1 X Natural 5 Pending 2 Accident Investigation (Month, Day,Year)	1 Yes 2 No								
Division of Vital Records, rate dear the law requirate dear death. The law requirate dear dear dear dear dear dear dear dea	ifica		nome, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rura	al Route Number, City						
Spital nours a neral I	Certification:	4 Homicide determined (Specify)		or Town, State)							
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ical	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination a	dge, death occurred at the time, date and place, an	nd due to the cause(s) and manner as starte	d.						
Park F m	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont							
1	-	10,1171	O.C.M.E.	May 18, 2006	n, Day, radi)						
n News		30. Name and address of person who completed cause of death (Item	4								
300		Theodore King MD. Assistant Medical Examine	,	21201							
	tate	te 31. Date filed (Month, Day, Year) MAY 2 5 2006 32 Registrar's Signature									
Regis	Tell	MAY 2 5 2006 Beause 1	" Lingues !								

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State of Maryland / Department of Health and Mental Hygiene 2 0 0 5

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		•	1 - State Registrar		(Certifica	ate of i	Death		Re	g. No.		10	0 1 1-
	Diam'r.		1. Decedent's Name (First, Middle, Las								n Day - C	Year		of Death
	Physici /Medio		Charles 1	lett, Jr	Jr. May					2006	. 041	12:	14 рм	
	Examin		4a. Facility Name (If not institution, given 238 Homeva.					Location of			4c. Count	y of Death Balti	more	
	Funeral Director		5. Social Security Number 6. S 220–24–9020 1	ex 7. Ag □xm 2□ F 7	e (In yrs. last birth 7 Y	rs. If Uni	der 1 Year ns Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, DeC • 17	1 928	9. Birthr Mary	place (State Tand	or Foreign
	pur *	}	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside	City Limits
	ehou	2	Md. Baltim	ore	Reiste		1							s 2 TNo
	28a-f	Director	10e. Street and Number				Zip Code			10	g. Citizen of	What Cou	nto/2	
	ath with		238 Home				2]	.136			U.	S.A.		
920	be filed within 72 hours after deeth with the Maryland hat Hygiene. Id other then "nature!' or Iteme 23a or 28a-f show event, if a Medical Examinar must be motified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1. Yes 2 1 If Yes, Give Year or Dates:	1052-	If Yes, s	cedent of H pecify Cuba 2/13/No	ispanic Orig in, Mexican, Specify:	jin? (Spec , Puerto R	ify Yes or No- ican, etc.)		ice - Americ ack, White, ify:		
5-0	72 hc	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. I	Decedent's U (Give kind of	work done	during most	of working	9	16b. Kind of E	3usiness/In	dustry	
2	within 72 ene. then "nai	Completed	Elementary/Secondary (0-12)	College (1-4or 5		(Give kind of work done during most of work life. DO NOT use retired) Manager					Bowl	ing C	0.	
12	e filed within at Hygiene. cather then 'vent, the Me		17. Father's Name (First, Middle, Last)	-		Halla	561	19 Mother	ric Namo	First, Middle, N				
Maryland 21215-0036	D 6 2 0	To Be	Charles B.		ir.					Rosalie				
-	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 is markeeny injury or other traumatic ODGE.		19a. Informant's Name/Relationship (Lillian M. Wa		19b. 238	Mailing Address Home	ess (Street vale l	and Number	ror Rumal Reist	Route Number, erstown	City or Towr Md.	n, State, Zip 2113		
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	y)	20b. Place of cemetery Marylar	crematory of	ar other oler	cem. M	Da lay 2	te 2 6, 2006	Owing	,		id.
Balt	permit. Departr Import. eny inj.		21. Signature of Hungra Service Lice	hhard	1	Eck	hardt	ss of Facility Funer	al C	hapel, Rd., O	P.A. wings		21117	
			23a. Part1. Enter the disease, or com shock, or heart ailure. List only	plications that caused one cause on each li	I the death. Do no								Approxima Interval Be	ate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Say	amous a consequence o	5 Cel	1	ions	mal	cell	Lung	Ca	Onset and	
П	Examiner		Sequentially list conditions,	b										
14/	D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o	f):								
ba	and and I-tran	хаш	that initiated events resulting in death) Last Due to (or as a consequence of):											-
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687	ificate g phy as the	Medicai		. u.										
.O. Box	The law requires that the death certificate be executed at hes been signed by the ettending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic 5 □ Other						ate of deliver	ery Day	Year
σ.	ires that t signed by I be detac	þ	Part II. Other significant conditions	ontributing to death b	ut not resulting in	the underlyin	g cause giv	en in Part I.		23e. Did tob	_		he cause of	
öro	w requir been si should	etec			-					1 Ye				
Vital Records,		Completed						· · · · · · · · · · · · · · · · · · ·		24a. Was ar autopsy perform 1 Yes 2	/	were auto prior to co death? 1 \(\sum \) Yes	ppsy finding: impletion of 22 No	s available cause of
Vita	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:			DOA Oth	er		Check only one			1	
of	Phys this al dir	၉	1 Yes 2 No 27. Manner of Death	1 🔲 Inpatie			DOA 28c. Injur	4 ∐ Nur		e 5 Reside			y)	
ion	nding ath. r: After e funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inju (<i>Month, D</i> a	y Year) In	ijury M	Wor	k? Yes 2 □ N		28d. Describe how injury occurred				
Division of	al or Atte s after des il Directo id in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			tory, office				(Street and Number or Rural Route Number, wn, State)			mber,
	To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a Certifier Certifying Pl (Check only 2 Medical Examone)	nysician: To the best niner: On the basis o and manner st	f examination and	death occum Vor investigat	ad at the tin ion, in my o	ra, date and pinion, deatl	d place, an	nd due to the ca d at the time, da	usu(s) and in te and place	anner 15 5 , and due to	tatud. o the cause	(s)
	To the Within To the comp	Me	29b. Signature and title of certifier				29c. Licens	e number		29	d. Date sign	ed (Month,	Day, Year)	
			Danot Co	the mi			NU	-611.	8	1	1Am	25K	- 2	006
	10		30. Name and address of person who	completed cause of o	leath (Item 23a) (Type, Print)	1	00	9			1.3		
_	У		JANET COOPE	RMD	1447	1/0	RK	Kd		uther	11/18	MD	210	193
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	South								

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F		lental Hy	/giene	006	16573
			1. Decedent's Name (First, Middle, Las	t)				2. Date of D		Vasa	3. Time of Death
	Physici /Medic		Allan Ba	iley Wel	den				24, Day 2	.006	5:05am ^M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. Co	unty of Death	
			Continuum Care			Syke	sville			Carro	011
	Funeral		Social Security Number 6. S		e (In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	irth	9. Birth	place (State or Foreign ntry)
	Director		1	X M 2□F	74 Yrs.	Williams Days	Tiours Will.		21, 19	31 NJ	y)
	pu ,		Usual Residence of Decedent 10a. State 10b. County		100 Cib. Town and						
	aryla shov	_	10a. State 10b. County Carr	011	10c. City, Town or L	ykesville				1	10d. Inside City Limits 1 ☐ Yes 2X☐ No
	88-1	Director									
	or 2		10e. Street and Number			10f. Zip Code			10g. Citizer	of What Cour	1
	ath v	ra	7203 Costello Cou				21784			USA	
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Itama 23a or 28a-f show event, "to Medical Ezam inclusive notified.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If If Yes, Give Year or Dates:	Everin U.S. 13. No Korea	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)		Race - Americ Black, White, pecify: W	
Maryland 21215-0036	houn tura	pe t	15. Decedent's Ed		R. I	edent's Usual Occup	ation		16h Kind	of Business/In	duetes
Ċ	filed within 72 Hygiene. other than "nai ant, the Medic	Completed	(Specify only highest gra	de completed)	(Give	e kind of work done of DO NOT use retired	during most of work	ing	TOD. IXIIIG	01 003111633/111	dustry
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0	filed wil Hygien other th		17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle	1		
a		To Be	John F. Welder				Unkno	•			
₹	2 should be and Mental is marked of sumatic ev	ř	19a. Informant's Name/Relationship (7	vpe. Print)	19b. Mail	ing Address (Street			her City or To	own State Zir	Codel
<u>8</u>	d 2 tha		Mr. Richard J. We			-					,
ģ	ges 1 and 2 should tof Health and Men if Item 27 is marks or other traumatic		20a. Method of Disposition		20b. Place of Disp	osition (Name of		Date		tion - City or To	
و	Pages nent of int: if it		1 ☐ Burial 2 ☑ Cremation 3 ☐		cemetery, cre	matory`or other plac ty Cremat	, I	12006		sville,	
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Ba Ba	permit. Pages 1 an Department of Heal Important: if Item 2 any Injury or other once.	0 3	Duan C- &	auch		AlGHI FUN Sykesvill	e, MD 217	84 (41)	0)-795	A (Box -1400	195)
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that cause one cause on each li		ter the mode of dyin	ng, such as cardiac	or respiratory a	arrest,	N	Approximate Interval Between Onset and Death
	/Medical Examiner		1	Due to (or as	a consequence of):						
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_	icate be executed physician and s the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
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	phys the	dicai		d							
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Ś	law requires that the desas been signed by the a	ğ	Part II. Other significant conditions of	ontributing to death t	out not resulting in the	underlying cause giv	en in Part I.		tobacco use Yes 2	2	he cause of death? Dably 4 🗍 Unknown
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	The fav	E o							ormed2	death?	mpletion of cause of
Vital	iffical	Ö	25. Was case referred to medical				26. Place of Deat	1 Yes	2 XNo	1 🗆 Yes	2 No
	Physiclan: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatie	ent 3 DOA Oth	er: Nursing Ho			Other (Specif	
ō	ar this		27. Manner of Death	28a. Date of Inju	ury 28b. Time			28d. Describe			у)
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S	Attendideath.	Certification;	3 Suicide 6 Could not be		jury - At home, farm, s			28f. Location	(Street and N	lumber or Rura	al Route Number.
2	after Direction by	erti	4 Homicide determined	building, e	tc. (Specify)			City or To	iwn, State)		·
	Hospita 4 hours Funeral	edical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best hiner: On the basis of and manner st	of my knowledge, dea of examination and/or i ated.	th occurred at the tin nvestigation, in my o	ne, date and place, pinion, death occurr	and due to the red at the time	cause(s) and date and pla	d manner as s ace, and due to	tated. o the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date s	igned (Month,	Day, Year)
	_		1 Mitha CA	1/2 1/1	2	Dog	60127		5/2	ulni	
	19		30. Name and address of person who	completed cause of	death (Item 23a) (Type	. Print)	1017/		110	1106	,
	\		William 11.	295 6	toner A	. p 5533	27 1.10	tonne	201	110 5	21150
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registi	rar's Signature	100	We	7 1 211216	in f		/
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ledical Examiner		ven 1	Mary	in C	Nall	ace	00	-		May 16, 20	006		2227	nrs
		Name (if not institution				41	Baltimore	or Location o	of Death		4c. Cc	ounty of Dea	tn	
		rsity of Maryland				11000		lf Hode	er 24Hrs.	8. Date of Birt	h/MM/DD/	~~~~ <u>1 a B</u>	urtholace (Sts	ate or
Funeral	_	ecurity Number	6. Sex	7. Age	(In yrs. last	birthday)	If Under 1 Ye Months Da			o. Date of bill	3	Fore	eign	
Director	215	90-9999	1 M 2	F (48	Yrs.				1000	19,1	977 0	Country) [Y	117
8	Usual Resident	dence of Decedent 10b. County		-	10c City Tr	own or Location							10d. Inside	e City Limits
w any	Toal State	Tob. County			2	11	- 0						1 Yes	s 2 No
Varyland 28a-f show d at once. ector	100 Street	and Number			IX	MING	10f. Zip Code			10	Og. Citizen	of What Co	untry?	
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ath wi	2		Married Arr	med Forces?		If Ye	s, specify Cub	an, Mexican	n, Puerto R	ican, etc.)		White, etc.		ļ.
ter death	3 Wid	lowed 4 Di	vorced If Yes, G	ive Year	No No	1	Yes 2	No specify:	<i>'</i> :		Spe	ecify: B	cck	
2 hours afte "natural" I Examine	15. Dece	dent's Education (Spe	or Dates	i:	pleted) 1	6a Decedent	s Usual Occup	oation (Give	kind of wo	rk done	16b. Kind	of Business	s/Industry	
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21215-0036 Juld be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica To Be Comple		's Name (First, Middle	e, Last)	> 11	0	λ	9	18. Mothe		First, Middle, N	Maiden Sui	mame)		
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Baltimo permit. Pag Department Important: injury or of	21. Signat	ure of Funeral Servic	e Licensee				W Nor	4		Dalta	3 m		301	in Home
	23a, Part I	I. Enter the disease, of	or complications	s that caused	the death. I	Do not enter th	e mode of dyir	ng, such as	cardiac or	respiratory arr	est, shock		Approxir	mate Interval
Physician /Medical	failur	e. List only one caus	se on each line.	hot Wound										n Onset and Death
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68 certificanting se as	past 1	12 months?	4	Live birth Pregnant at	time of dea	2 Fe	ner (Specify)	3 Ectop	oic pregnar	icy	141	Onai	Day)
b. Box 68 the death certification of the attending ched for use as Physician	1 Yes	s 2 No 9 U	Jnknown 9	Unknown		0 00	iei (epoony)				1			
Records, P.O. Box 68 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as completed by Physician		ther significant cond	ditions contrib	outing to deat	h but not re	sulting in the u	nderlying caus	se given in F	Part I.				to the cause	
P.C res that signed be deta	<u> </u>									1Ye	s 2 🗸 N		robably 4	
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Division of Vital Records, P.O. rate death or Attending Physician: The law requires that the and refer death. After this certificate has been signed by led in by the funeral director, page 2 should be detach by the funeral director, page 2 should be detach and the page 1.	27 Mann	er of Death	28	Ba. Date of Injune (Month, Day May 16, 200		28b. Time of I 2158 hrs	njury 28c.	Injury at Wo	19	28d Describe Subject sho		occurred /		
ion tendin eath.			ending vestigation				1	Yes 2						
or At Sine of Direct in by	3 S	Suicide 6 C	ould not be	8e. Place of li	njury - At ho	me, farm, stre	et, factory, offi	ce building,		28f. Location or Town,	State)			
Division o Bostial or Attending 24 hours after death rely filled in by the fune	4 V H	Homicide	1	Specify) Lo						1900 block				טו
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		e and address of person Locke MD.	on who comples Assistant N			∠3a) 111 Peni	Street, Ba	altimore.	MD 212	01				
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		artment of Health and Mertificate of Death	Reg. No.	006 165/5
Physician /Medical			2. Date of Death Month 24 24	3. Time of Death 1:12A M
Examiner	a min man had deferred to the second of the	4b. City, Town, or Location of Death TOWSON	4c. Co	ounty of Death Baltimore
Funeral Director	5. Social Security Number 6. Sex 1XXM 2 F 59 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth October 12, 1946	9. Birthplace (State or Foreign Mary) and
Nyland how	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or b	ocation		10d. Inside City Limits
1 21215-0036 CLL // led within 72 hours after death with the Maryland bygiene. har than "natural; or Itams 23a or 28a-1 show it, the Madical Examiner must be notified at Completed by Funeral Director	Maryland Baltimore Towson	10f. Zip Code	10g Citizer	1 ☐ Yes 2 XX No
uffer death with the Marriages 23a or 28a-1 s right must be notified.	7 Cuyler Court	21204		USA
al, or ita	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spulf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes XX No Specify:		Race - American Indian, Black, White, etc. Decify: White
nar than "natural; it, it is Medical is Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing	of Business/Industry nufacturing
arkad othar atic evant, I	17. Father's Name (First, Middle, Last)	18. Mother's Name	ine Fletcher	
and 2 should eaith and Men n 27 is marks ier traumstic.	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rura Rutherford Road Suite		
ff itam ff itam or other	20a. Method of Disposition 1 100 Surial 2 Cremation 3 Removal from State	osition (Name of Impactory or other place)	Date 20c. Locat	ion - City or Town, State
Departmen Important: any injury ODGS.	14 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Co	2. Name and Address of Facility Mit	chell-Wiedefeld	ore, Maryland Funeral Home Inc re, Maryland 21212
Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			Approximate Interval Between Onset and Death
/Medical xaminer	resulting in death) Due to (or as a consequence of):	Mays direase		GAR
physician and street transit is the burial-transit dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	ir mys Critise		Jevis
use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	23d.	. Date of delivery Month Day Year
igne be d	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did tobacco use o	contribute to the cause of death?
has pe 2			24a. Was an autopsy performed? 1 Yes 2 No	4b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
s certification	25. Was case reterred to medical examiner?	26. Place of Death		Ther (Specify) HOSPICE
ding h. After fune fune			28d. Describe how injury oc	
within 24 hours after death. To tha Funeral Diractor: After completely filled in by the funer. Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and No City or Town, State)	umber or Rural Route Number,
in 24 hour ha Funer pletely fille		h occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause(s) and ed at the time, date and pla	d manner as stated. ce, and due to the cause(s)
To th comp	29b. Signature and title of certifier	29c. License number	29d. Date sig	gned (Month, Day, Year) 7 24 2-006
3	30. Name and address of person who completed cause of death (Item 23a) (Type AAN N J. CHANEL MO)	Print) 6601 N. CHAR.	ZIZOH	
State Registrar	31. Date filed (Month, Day, Year) MAY 2, 5, 2006 Single-sear & Common		21207	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes o o

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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		10		30. Nime end address of person who	completed cause of de	eath (Item 23e)	(Type, Print)	v oocl	AVE BA	LTUME	212	24	
			-	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	# 1702	****		-		•	

DHMH 16 Rev 6/95

Extended Family Assisted Living

College Manor

		•	For State Registrar	State of M	laryland / De	epartmen Certificat			nd Me		ene	006	16577
ı	Physici /Medic		1. Decedent's Name (First, Middle, La		Allen, S	Sr.			2	Date of Death	24,	2006	3. Time of Death 217:421 A
	Examir		4a. Fesiliy Name (If net institution for	esteet and number	Center	4b. City,	Town, or	Location of	Death WSOT)	4c. Cou	Balt	imore
然.	Funeral Director		220-40-8953	Sex 7. A	ge (In yrs. last birtho 62 Yr	Months	1 Year Days	If Under 24 Hours	4 Hrs. 8	B. Date of Birth (Month, Day, oct. 13,	1943	Coun	lace (State or Foreign try) Land
	e Maryland	ctor	Usual Residence of Decedent 10a. State Maryland 10b. County	N/A	10c. City, Town o		ltimo	ore				11	0d. Inside City Limits 1 XXes 2 □ No
	th with th	ai Director	10e. Street and Number 3748 Hickory A	venue		10f. Zip	Code	21	211	10	g. Citizen (of What Coun USA	try?
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The the marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinations the notified at	by Funerai	11. Marital Status 1 Never Married AMArried 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Tyes 29 If Yes, Give Year or Dates:	No	13. Was Deced If Yes, spec		spanic Origi n, Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)		lace - Americ lack, White, o	
21215-0	d within 72 ho jiene. rr then "natur rn Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 8th	ducation a <i>de completed)</i> College (1-4or	(0)	ecedent's Usua Give kind of wo fe. DO NOT us Auto	rk done a se retired,	uring most o	of working	1		Business/Ind	e Repair
\subseteq	2 should be filler n and Mental Hyg ts marked other raumatic event.	To Be C	17. Father's Name (First, Middle, Last James Herbert							First, Middle, Mi n Bell	aiden Sum	ame)	
	1 and 2 sho Health and I tem 27 ts ma		19a. Informant's Name/Relationship (Diane Allen (W	Туре, Print) ife)		lailing Address 18 Hicko				Ro <i>ute Number,</i> altimor	,		
Ö	Pages 1 nent of He ant: if iten ury or oth		20a. Method of Disposition 1 🛱 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	20b. Place of D cometery, Lake Vi	isposition (Nar. crematory or o LEW MEM	ne of ther place Oria) Park	Dai 5/2			n - City or To burg ,	_{wn, State} Maryland
Balt	permit. Pages Department of Important: If it eny injury or o		21. Signalu Funeral Service Lice	luput		22. Name an Burgee 3631 Fa	d Addres -Hens alls	s of Facility SS-Sei Road	tz F Bal	uneral l timore,	Home, Mary	Inc.	21211
4 . 4 . 4 .	Physician /Medical Examiner	ner	23a-Part*. Enter the disease, or common shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Each Indepting	Due to (or as	d the death. Do not ine. TATIC LU s a consequence of)	NG CAN	e of dying	, such as ca	ardiac or r	espiratory arres	it,		Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and id for use as the burial-transit	edicai Examiner	cause, 'Enter Undertying' Cause, (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of)								
.O. Box (at the death certific by the attending p lached for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		of pregnancy 2 □ Fetal death It time of death	3 ☐ Ectopic pr 5 ☐ Other (sp					1	Date of delive Month	ry Day Year
rds, P	quires that n signed t uld be det	by	Part II. Dther significant conditions	contributing to death I	out not resulting in th	ne underlying c	ause giv <i>e</i>	n in Part I.					e cause of death? ably 4 DUnknown
	 The law requires that the cate has been signed by th page 2 should be detache 	Completed								24a. Was an autopsy performe		prior to con death?	psy findings available apletion of cause of
Division of Vital	or Attending Physician: The fifer death. Director: After this certificate in by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Autural 5 Pending 2 Accident investigation	Hospital: 1 X Inpati 28a. Date of Inj (Month, Da	ury 28b. Tim		8c. Injury Work	r: 4 🗌 Nurs	sing Home	Check on N one 5 ☐ Residen d. Describe how)
DIVIS	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	286. Place of in	jury - At home, farm tc. (Specify)	, street, factory	r, office		28	f. Location (Stre City or Town,	et and Nui State)	mber or Rural	Route Number,
	ne Hospital n 24 hours a ne Funeral I oletely filled	edicai	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best miner: On the basis of and manner s	of examination and/o	leath occurred or investigation,	at the time, in my op	e, date and inion, death	place, and occurred	d due to the cau at the time, date	se(s) and i	manner as sta e, and due to	ated. the cause(s)
}	To the I within 2. To the Complet	M	29b. Signature and title of certifier	Som			3725			290	I. Date sign	4 / 66	*
	Ŋ			M.D. 76	Ø1 OSLEI		E	rowso	N, MA	ARYLANI	218	204	
4	Sta Registr	- 5.00	31. Date filed (Month, Day, Year) MAY 2 6 2006	32. Regist	rar's Signature	A STATE OF THE PARTY OF THE PAR							

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 24, 1006 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner)ohns Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 216-24-939 1 M 20 F Yrs. Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b County 10d. Inside City Limits 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? APT-620 21205 57 21.5 Funeral filed within 72 hours after deeth tame 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 Yes 2 No Specify: Specify: BlACK δ 3. Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) CARE ai Hygiene. OF HOME College (1-4or 5+) None Honemacken permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie. Importent: if item 27 is marked other 11 any injury or other traumatic avent. Itta once. gRAde 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ChAVIS Jessie IDEA Jone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TRene 6:57 1400 E. MAdison 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 18 Burial 2 Cremation 3 Removal from State Mem. Pk 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BeTTS FUNERAL HO SILL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ISCHEMIC cardiomyopathy months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner artery JOYONGVY VEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner anding physicien and use as the burial-transit Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) ate hes been signed by the e page 2 should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pulmonary 3 Probably 4 Unknown 1 XYes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate hes funeral director, page 2: autopsy performed? 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pendina death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funaral Diractor: completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 5 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) ANGELINE CHONG, MEDICAL DOCTOR RES-000 MAY 25,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. BAltimore, MARYLANG 600 ANGELINE CHON 6 N. Walfis 31. Date filed (Month, Day, Year) 3. Registrar's Signature MAY 2 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 45 pm 2006 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Samaritan Balt If Under 1 Year If Under 24 Hrs.
Wonths Days Hours ood 105 nital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Aug. 24, 19 Birthplace (State or Foreign Country) **Funeral** 1□M 2 F Months 227-28-2502 Director 1917 Virginia Aug. Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "naturel", or iteme 23s or 28s-f show the Modical Examiner must be notified at 1XYes 2 No Director MD n/a Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 1517 Woodbourne Ave. 21239 Completed by Funeral USA 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: white Specify: 3 Nidowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Bakers Helper A&P Bakery 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liqury or other traumatic event 9DRS. Be 18. Mother's Name (First, Middle, Maiden Sumame) Walter Rose Victoria Cool 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Merritt - Daughter 1517 Woodbourne Ave. Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory May 26, 06 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 23a. Part I Enter the disease, or complications that cause at the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tip. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Pneumonia Examiner Sider Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (o) as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 ettending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No the funeral director. Be 25. Was case referred to medical 26. Place of Death Check only on examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient ٩ 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 □ Yes 2 □ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitei of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of o 29c. License number 29d. Date signed (Month, Day, Year) 63382 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Paven Blud, Battimare

DMitrix Pin Dii

State Registrar

Jui 451A

31. Date filed (Month, Day, Year)

Registrar's Signature

21234

			1 - For State Registrar	State of Man		partment of I	lealth and Mo	ental Hygie	4000	16580
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Las 4a. Facility Name (If not institution, give	Mar	y C. Cent	11	recik	2. Date of Death Month May 2	Day Year 2 0 C 4c. County of Deat	
ų,	Funeral Director		5. Social Security Number 6. Se		n yrs. last birthda 83 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Jan. 20, 19	9. Bird 923 Ba1	thplace (State or Foreign buntry) timore, MD
	he Maryland 8a-f ehow ctiffed at	ector	10a. State 10b. County MD	- 11	Oc. City, Town or Baltir	more				10d. Inside City Limits 1 ■Yes 2 □ No
	3 or 3	JO I	10e. Street and Number 3320 Benson Ave			10f. Zip Code 212	27	10g.	Citizen of What Co USA	untry?
9036	d within 72 hours after death with the Maryland jiene. Ir then "naturel", or Items 23a or 28a-1 ehow the Mooissal Examinat-must be natified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Wildowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	er in U.S. 1	3. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Specian, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit Specify: Wh	
Maryland 21215-0036	y within jiene.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) Cotlege (1-4or 5+)	(Gi	cedent's Usual Occup ve kind of work done o. OO NOT use retire ecretary	during most of working	9	Kind of Business/	,
yland ;	outd be file Mental Hyg arked other	To Be C	17. Father's Name (First, Middle, Last) Joseph Walsh					cine McEl	gunn.	
	and 2 sho ealth and n 27 le m		19a. Informant's Name/Relationship (7 Catherine E. Ward / I				and Number or Rural t Marco Islan			(ip Code) .
Baltimore,			20a. Method of Disposition 1	I I I I I I I I I I I I I I I I I I I	20b. Place of Dis cemetery, c New Cathe	position (Name of rematory or other place of carete)	ce) May 2 ry 2006	77	Location - City or altimore, M	
Balt	permit. Page Department of Important: If eny Injury or		21. Signature of Funeral Service Licen	`		TOOT Fast	ess of Facility L. Stevens I t Fort Ave Ba	<u>ltimore</u> MD	e Inc. 21230	
	rnysician /Medical Examiner	er	23a. Part1. Enter the disease, or composition in the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	one cause on each line.	onsequence of):		. 1 1	1 1	کا د	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):					
P.O. Box 6	I the death certification by the attending placement ached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	/		23d. Date of deli	very Day Year
	law requires that the de as been signed by the a 2 should be detached		Pan II. Other significant conditions co	intributing to death but n	ot resulting in the	underlying cause giv	en in Part I.	23e. Did tobacc	_	the cause of death?
Division of Vital Records,	The lar ate has page 2	Completed by	Chronic obst	ructive	pulma	mary o	lisease	24a. Was an autopsy performed?	prior to c death?	lopsy findings available completion of cause of 2 No
Z.	ysiclan: Th s certificate director, pag	To Be	25. Was case referred to medical examiner?	Hospital:	2 ☐ ER/Outpat	ent 3 DOA Oth	26. Place of Death	Check only one	6 DOM: (C	4.1
ion of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certifica completely illied in by the funeral director.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye		of 28c. Injur		d. Describe how in		ny)
Divis	To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (\$	Specify)			f. Location (Street City or Town, Sta	ate)	
	To the Hospital within 24 hours and the Funeral I completely filled	edical	29a. Certifier (Check only one) 1. Certifying Phy 2 Medical Exam	rsician: To the best of m iner: On the basis of ex- and manner stated	amination and/or	ath occurred at the tin investigation, in my o	ne, date and place, an pinion, death occurred	d due to the cause at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
)	To the comp	W	29b. Signature and title of certifier	ng/1	no	29c. Licens	e number 91	29d. C	Date signed (Month)	Day, Year)
	N		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Typ	e, Print)	timore 1	Maryla	nd 2	1227
the street	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1.16				

			1 - State Registrar	State of	of Marylan	d / Depa		t of H	ealth a	and N	-) 0 6	16581
- Sp	To see		Decedent's Name (First, Middle,	Last)							2. Date of D	eath		3. Time of Death
	Physici /Media		Augusta Butler								Month	Day 23	Year 2006	7:30 a. M
	Examir		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City,	Town, or	Location	of Death	-		inty of Deatl	
			1701 Evergreen 5. Social Security Number	Drive				unda				Bal	timor	
N	Funeral			6. Sex 1 ☐ M 2 ☒ F	7. Age (In yrs.	last birthday) Yrs.	If Under Months		If Under Hours		8. Date of Bi (Month, D	rth ay, Year)	9. Birtl	hplece (State or Foreigi untry)
L.	Director	Š	213-07-5764 Usual Residence of Decedent		86	113.					Sept.2	4,1919	Mar	yland
	within 72 hours after death with the Maryland ene. than "naturel", or itema 23a or 28a-1 ehow ra Mudical Examinar must be notified at		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
	Mar.	tor	Maryland Balt	imore	D	undalk								1 ☐ Yes 2 🔯 No
	th the	Director	10e. Street and Number		•		10f. Zip	Code				10g. Citizen	of What Co	untry?
	th wil		1701 Evergreen	Orive			2	1222				Unite	d Sta	tes
	r dea	Funerai	11. Marital Status		edent Ever in U	.S. 13.	Was Deced	lent of Hi	spanic Ori	igin? (Sp	ecify Yes or N Rican, etc.)			rican Indian,
36	or it	by Fu	1 Never Married 2 Marrie	If Yes, G	ve -		1 ☐ Yes 2		Specify:		,		cifv:	, 010.
2-0036	hours	d D	3 XWidowed 4 Divorced	Year or E	Dates:				***				Wh	nite
5	in 72	Completed	15. Decedent (Specify only highes	grade completed)		(Give	dent's Usua kind of wor DO NOT us	rk done d	luring mos	it of work	ing	16b, Kind o	/ Business/I	ndustry
72	with iene.	E O	Elementary/Secondary (0-12) 12 years	College (1-4or 5+)		maker		,			Own	Home	
D	filed Hygie other	Bec	17. Father's Name (First, Middle, L	ast)		1104116.	iiaize,		18. Mothe	er's Nam	e (First, Middle			
Maryland 2121	lid be hental rked o	To B	Herman Yeager						Henr	riett	a Blis	chki		
ary	should and Men s marke umatic		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rur	al Route Numb	er, City or To	wn, State, Z	ip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. item 27 is marked other than "naturel", or itema 23a or 28a-1 show other traumatic event, it a Muulcal Examit at must be notified at		James Butler	(Son)		1701	Ever	gree	n Dri	ve	Dunda	lk, Mai	cyland	1 21222
Sre	of He of He fiten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Domewal from		Place of Dispo	sition (Nam	ne of			Date	20c. Locatio	n - City or	Fown, State
Ĕ	Pag nent ant: I		4 □ Donation 5 □ Other (Sp		Hi	11top	Servi	ce C	orp	5/24	1/2006	Tows	on, Ma	aryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any njury or other trai		21. Signature of Foneral Service L	icensee	V		2. Name the				25 52	ier o i	- E	
<u> </u>	997		TOPL	arrich	1 asx	24	922 W	ick ise	Funer Avenu	al I	loτe of Oundalk	Lundal Mary	lk, Ir	1222
T.			23a. P 11. Eme the dilease, or shock, or heart failure. List of	complications that only one cause on	caused the deat each line.	o not ent	er the mode	e of dying	g, such as	cardiac	or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Cor	ZONAP	A F	RTE	ERY	T	SISE	ASE			Onset and Death
	/Medical Examiner	ě	resulting in death)		(or as a conseq								1	
l.	Examiner	_	Sequentially list conditions	The second second	HERD:		E RO	SIS						1576AF
	be sit	ine	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a conseq	,								
Ρ.	le be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	0.	Or as a conseq		N		_					20YEAR
.09	be ey	cal E			(0) 43 4 6011394	derice or).								
687	phys the			d									-	
	certif iding	/Me	IF FEMALE:	23c. If yes, ou	tcome of pregna	ancv						224	Data of dali	
P.O. Box	Attending Physician: The law requires that the death certificate be executed reath. -ctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burral-transit	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1☐Live	birth 2 Feta	Ideath 3[Ectopic pre						Date of delin Month	Day Year
o.	the cather	hysi	9 Unknown	9□ Unkr	iown			,,						
	s that ined be e det	y P	Part II. Other significant condition	ns contributing to o	leath but not res	ulting in the u	nderlying ca	ause give	n in Part I		23e. Did	tobacco use c	ontribute to	the cause of death?
ğ	quire an sig uld b	ed	ATRIAL F	1BRILL	NOMA	٧					1 🗆	Yes 2□No	3 🗆 Pro	obably 4 Unknown
Vital Records,	aw re	Completed	ANEMIA.								24a. Was		b. Were au	topsy findings available
æ	The I	E										ormed?	death?	ompletion of cause of
<u> </u>	ian: rtifica stor, p	Bec	25. Was case referred to medical			100			26. Place	of Deat	1 ☐ Yes		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	213480
	nysic direc	ToE	examiner? 1 ☐ Yes 2 ØNo.	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DO	A Othe			me 5 🖄 Res		Other (Spec	afy)
0	ng Pl		27. Manner of Death 1 SNatural 5 Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury	28	Bc. Injury Work			28d. Describe			
<u>0</u>	•ndii eath: or: A	catic	2 Accident investig	ation			М		/es 2 🗌	No				
Division of	or Att	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 208. Place	e of Injury - At he ling, etc. (Specif	ome, farm, str y)	eet, factory	, office			28f. Location (City or To	Street and Nu wn, State)	mber or Rui	ral Route Number,
	oltal c													
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier Certifying (Check only 2 Medical E	Physician: To the taxaminer: On the tax	e best of my kno pasis of examina iner stated.	owledge, deat ition and/or in	n occurred a vestigation,	at the tim in my op	e, date an pinion, dea	id place, ith occurr	and due to the ed at the time,	date and place	manner as	stated. to the cause(s)
	o the ithin i	Me	29b. Signature and title of certifier	andmat	11161 5(4(40).		29c.	. License	number	· · · · · ·		29d. Date sig	ned (Month	Day, Year)
	r sr ö		10	5	ch	M.D.		D 3	334	07.		5/	MICI	
	10		30. Name and address of person v	who completed cau	se of death (Iten	n 23a) (Type.	Print)					2/0	12/00	
	W		Deepak Set	h.M.D	744	4 No	lahi	rd	AUG	2.5	te.D	B	Ito.	MD.2122
73	Sta		31. Date filed (Month, Day, Year)		istrar's Signa	ature								, , , ,
2	Regist	ar	MAY 2	6 2006	Loters.	13. July	best							
DI	IMU 17 Day 1/2	001		450		6								

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	aryland /	Depart	ment of		and M	lental Hyg	_	006	16582
	6		Decedent's Name (First, Middle, Last	1)						2. Date of Dea	th		3. Time of Death
	Physici		Doris O. Bar	ker						May 23	, 2006	Year	9:37 A M
	/Medic Examin		4a. Facility Name (If not institution, give		r)	4	b. City, Town	n, or Location	of Death	1149 25	4c. County	of Death	9.31 A
	Examin	er	Greater Baltimo				Towso				Ba1	timore	
	Funeval		Social Security Number 6. S		ge (In yrs. last i	birthday) 1	f Under 1 Ye	ar If Under		8. Date of Birth	,	9. Birthola	ce (State or Foreign
	Funeral Director			⊒м 2 X) F	85	Yrs.	fonths Day	ys Hours	Min.	July 25	Yearl I	Mary	land
			Usual Residence of Decedent							ourj 20	, 1320		
	yian		10a. State 10b. County		10c. City, To	own or Locat	ion					100	d. Inside City Limits
	Mai	ğ	Maryland Baltim	ore Co.	(Glen A	rm						1 Yes 2 No
	h the	Director	10e. Street and Number				10f. Zip Cod	ө			log. Citizen of \	What Countr	y?
	urs after death with the Maryiand ei', or iteme 23e or 28e-f ehow Examiner must be notilied et		11630 Glen Arm	Road			21	057			Unit	ed Sta	ates
		Funeral	11. Maritaf Status	12. Was Deceden	t Ever in U.S.	13. Was	s Decedent o	of Hispanic Ori	igin? (Spe	ecify Yes or No- Rican, etc.)	14. Rac	e - Americar ck, White, et	
	or its	E.	1 ☐ Never Married 2 ☐ Married	Armed Forces 1 ☐ Yes 2 ☐ ff Yes, Give	No	1	Yes 2				Specify		
\1,5		d by	3 A Widowed 4 □ Divorced	Year or Dates	:							MILIT	
$\sum_{b} R_{i} \lesssim 21215-0036$	72 hours aft "naturel", or adical Exemi	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16	Sa. Deceden (Give kin	t's Usual Oct of work do	cupation ne during mos tired)	t of worki	ng	16b. Kind of B	usiness/Indu	istry
2 2	of thin	d III	Elementary/Secondary (0-12)	Colfege (1-4o	5+)		memake				0.00	Home	
	lled v tygie ther t		12 yrs.			110	iliciliane		ar's Name	(First, Middle,			
Ž	be fi	Be		0.000				TO, MOLIN		•		10)	
Q'\ <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u>	2 should be filed and Mental Hygi ie marked other aumatic event,	2		orne		05 14-10			Min		llmann	0	N- 7-1
BARKER, imore, Maryland	12 st h and 7 te n		19a. Informant's Name/Relationship (T Mrs. Ellen Lee Ad			=		· Avenu		al + i move			·
2.K	s 1 and 3 of Health Item 27 other tr	1	20a. Method of Disposition	ما ۱ ما ۱۱ م	-					altimore Date	20c. Location -		
A PO	if life or of or o	1 2	1 ☐ Burial 2 🛣 Cremation 3 🗍			of Disposition							
₩ Ë	tmen tant:	. 8	4 Donation 5 Other (Specify					Corp.		0/2006	Towson		
SAR. Baltimore,	permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "natu any Injury or other traumatic event, the Modical ODGs.		21. Signature of Funeral Service Licens	Michae	l Canapp			dress of Facili	*	T			rd Road
	TO 2 4 G		Million.CZ	74	- 1 th - 1 - 1 - D			d J. R				more,	MD 21214 Approximate
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each	line.	A	ne mode or c	aying, such as	cardiac	or respiratory an	est,	1 1	nterval Between Onset and Death
	Physician		fmmediate Cause (Final disease or condition resulting in death)	a. PNE	ZUMDA	SUFF	,60	13A16					weck
	/Medical Examiner		resulting in death)	Due to (or a	N L E	ce of):	e r.	1000	1	AA11	11 DIA		11116
	_xanimio,		Sequentially list conditions.	0	s a consequence		7 4	41201	me	FAIL	012	/	vee
1	slt ed	la Per	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	AFI	DIM.	æ or): ⊿1	II B	RILL	1	Lan		7	JERK
A	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to /or a	s a consequenc	e of):	113	KICC	- 12-1	701-			MERCI
760,	be exicient	calE		((RON	AR	4 1	RIF	RY	DURE	AS13	10	DYBARO
687	~ ~ ~		•	d	,, ,		/ 0		(,	/	1=1-5
9 ×	ding	/Me	IF FEMALE:	23c. If yes, outcom	e of pregnancy					•	004 Da		
Bo	atten for u	lan	in the past 12 months?	1 Live birth	2 ☐ Fetal dea at time of death	ath 3⊟Ec	topic pregna ther <i>(specify)</i>				Mo	te of delivery nth D	ay Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	at time or death	3110	ther (specify)	/					
۵.	thet t ed by deter	된	Part fi. Other significant conditions co	ontributing to death	but not resulting	g in the unde	erlying cause	given in Part I		23e. Did to	bacco use cont	nbute to the	cause of death?
Division of Vital Records, P.O. Box	Attending Physician: The law requires thet the death certificate be exdeath. sctor. After this certificate has been signed by the attending physicien by the funeral director, page 2 should be deteched for use as the buria	Completed by Physiclan/Med	CHARET	ES h	18 Li	170	7 2	T		1 🗆 Y	es 2 No	3 Probab	oly 4 🗀 Unknown
Š	v requ	ete	CT. BOR	BA						24a. Was a	245.1	Mara autoria	us findana available
Rec	a a c	E E	GL GC	1 De la						autop:	SV I	prior to comp death?	y findings available pletion of cause of
<u>=</u>	n: The		DEMEN	7 1 (16)-						1 Yes	2 2 00	∏Yes 2	□ No
× ×	riciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:				Other		(Check only of			
ŏ	Phys ral di	P.	1 Yes 2 No 27. Manner of Death	28a. Date of In		Outpatient o. Time of	3LI DOA	njury at		me 5 Resid			
5	ding After tune	흔	1 Natural 5 Pending	(Month, D	ay Year)	Injury	٧	Work? ☐ Yes 2☐		2007 2000 100 17	ow injury occur	04	
<u>.is</u>	deat deat ctor: y the	lca	3 Suicide 6 Could not be		njury - At home,	farm, street				28f. Location (S	treet and Numb	er or Rural F	Route Number
N	or effer Dire	Certification:	4 ☐ Homicide determined		etc. (Specify)	12.111, 50, 500	, 120,017, 01111			City or Tow	n, State)		
	spita lours neral fillec		29a. Certifier To Certifying Phy	/sician: To the bes	st of my knowled	dge, death of	ccurred at the	e time, date ar	nd place, a	and due to the o	ause(s) and ma	nner as stat	ed.
	the Hospital nin 24 hours e the Funeral I npletely filled	Medical	(Check only 2 Medical Exam	iner: On the basis and manner:	of examination	and/or inves	tigation, in m	y opinion, dea	th occurr	ed at the time, o	late and place,	and due to ti	he cause(s)
_	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page:	Me	266. Signature and title of certifier		-	\	29c. Lice	ense number		. 2	9d. Date signe	Month, Da	ay, Year)
	- >- 0	1	RAN	VAN AG	MARAH	NM	1) =)512	13-		51	241	2006
	1	`	30 Name and address of person who o	completed cause of	death (Item 23)	a) (Type) Pri	nth (1)		. \	(1	1 12	1 / -	M 20 0
	5		RAMANA GOT	HUAN	Wil) 1/	2.10	ILLI W	~/	RAST	459 1	HUTC	1111/2/23
	Sta	ite	31. Date filed (Month, Day, Year)	32. Fegis	trar's Signature	A.	Als B						
	Registi	ar	MAY 2 6 21	006	in It	199							

			T = For State Registrer	State of Marylan		rtment of F		_	giene (16	16583
	Physici		1. Decedent's Name (First, Middle, Last	Burr	ell			2. Date of De Month	Day	Year	3. Time of Death 8:45 AM
	/Medic Examin		4a. Facility Name (If not institution, give Alice Manor Nursi			4b. City, Town, o	r Location of Dea	th	4c. County	of Death	
	Funeral Director		5. Social Security Number 6. Se 218-22-9203		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year)	9. Birthpl Count Mary]	• ,
	r 28e-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD 10e. Street and Number		y, Town or Lo	cation			10g. Citizen of W		od. Inside City Limits 1⊠ Yes 2 □ No
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other then "naturel", or Items 23e or 28e-f show or other treumatic event, the Medical Examinar must be notified at	by Funerai	3700 N. Charles S 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1Yes_2No If Yes, Give Year or Dates:	'	2121 Vas Decedent of Fires, specify Cub.	lispanic Origin? (Specify Yes or No nto Rican, etc.)	USA 14. Race Black	- America k, White, e whit	etc.
21215-0036	d within 72 h glene. Ir then "natu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	coation de completed) College (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retired Desk C1	during most of wo d)	orking	16b. Kind of Bu	siness/Ind	ustry
Maryland ;	12 should be filed within "n and Mental Hyglene." I'ls marked other then "reumatic event, the Med	To Be C	17. Father's Name (First, Middle, Last)			unk	18. Mother's Na	me (First, Middle,	Maiden Sumame	e)	unk
Baltimore, Mar	permit. Pages 1 and 2 sho Department of Health and Importent: If item 27 Is my any injury or other treum once.		19a. Informant's Name/Relationship (T. Alice Manor Nursi 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 ☒ Other (Specify,	ng Home 20b. F	2095 Place of Dispo	da est	Ave. Ba	tural Route Number 1t1more, Date	5 55565	1	
Balt	permit. Departr Importe any inju		21. Signature of Funeral Pervice Licens Royald S	Wade precto	r S B	altimore	tomy Boa MD 212	rd 655 W 01		ore S	Street
8760,	whysician and words the burial-transit	dical Examiner	23a. Nart1. Enter the disease, or compshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Ener underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the death	uence of):	Kelme		\mathcal{D}_{ℓ}			Approximate Interval Batween Onset and Death
.O. Box 6	death certific e attending p ed for use as	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pregnancy Other (specify)	′		23d. Date Mon	of deliver	y Day Year
Δ.	Se De		Part II. Other significent conditions or	ontributing to death but not res	ulting in the u	nderlying cause giv	ren in Part I.		obacco use contri ∕es 2□No		cause of death?
Vital Records,	The taw require ate has been sin page 2 should b	Completed						24a. Was autop perfo 1 \sum Yes	rmed? pi	Vere autoprior to comeath?	sy findings available pletion of cause of
ita	icien: Th certificate ector, pag	BeC	25. Was case referred to medical examiner?				-	ath (Check only o	ne)		
Division of V	iing Phys I. After this I	ို	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	4 Hoursing	Home 5 Resid	dence 6 Othe		
Divisi	el or Attending s after death. Il Director: After od in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, str	eet, factory, office		28f. Location (\$ City or Tov	Street and Numbe vn, State)	r or Rural	Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medicel Exem	ysician: To the best of my kno iner: On the basis of examina and manner stated.		estigation, in my o	pinion, death occ	urred at the time,	date and place, a	nd due to	the cause(s)
)	with To	M	29b. Signature and title of certifier	m 1	My	29c. Licens	314 b	4	29d. Date signed	(Month, D	(
	Sta Regist		30. Name and address of person who can be seen a seen and address of person who can be seen a seen and address of person who can be seen a see	A Registrar's Signa	21 N	· CMTAI	N ST &	mite I	N BAI	LTIM	100CF MY 2/16/

		1	= For Amend #10a	-f Per	State of	%19/19	nd _H Depa	artment of rtificate o	Health f Death	and M	lental Hyg R	iene2	006	16584
			1. Decedent's Name (First, A	liddle, Last)						2. Date of Deat Month	lh Day	Year	3. Time of Death
	Physicia /Medic		Cyril Josep	h Bow	dring						05		2006	6:30a M
1	Examin		4a. Facility Name (If not insti-	ution, give	street and numb	oer)		4b. City, Town	, or Location	of Death		4c. Co	unty of Death	
			5101 River	Rd. A	pt713			Bethe	esda			Mo	ntgome	ry
	Funeral Director		5. Social Security Number 027-18-6452	6. Se	x 7. 24M 2□F	Age (In yrs.	last birthday) Yrs.	If Under 1 Yes Months Day		Min.	8. Date of Birth (Month, Day, 12-22-	Year)	Cou	place (State or Foreign ntry) ston, MA
	p .	-	Usual Residence of Deceder 10a, State 10b, Co	t unty Marri	ioono	10c Ci	ty, Town or Lo	ncation						10d. Inside City Limits
	Aaryla Febor	5		atgom			Bethes		tsdale					1⊠Yes 2 □ No
	28a-	Director	10e. Street and Number	676 N	SCottsda	ile Rd.		10f. Zip Code)		1	0g. Citizen	of What Cou	ntry?
	3a or		5101 River						20816	s 852	53	U	SA	
	me 2	Funeral	11. Maritat Status		12. Was Deced	ent Ever in U	J.S. 13.	Was Decedent of	f Hispanic Or	rigin? (Sp	ecify Yes or No-		Race - Amen	
920	J within 72 hours after death with the Maryland ilen. Jien. The Macreal Examiner must be notified at the Macreal Examiner must be not	Ď	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☒ Divo		Armed Force 1 XYes 2 If Yes, Give Year or Date	□no 19	46	If Yes, specify C 1 ☐ Yes 2 🔼 N			nican, etc.)		Black, White, ecity: Whi	
9	72 ho	ted	15. Dec (Specify only h	edent's Edu			16a. Dece	dent's Usual Occ	cupation	st of work	ina	16b. Kind	of Business/Ir	ndustry
2	ithin 7	Completed	Elementary/Secondary (0-		College (1-4	or 5+)	life.	DO NOTuse ret irance l	ired)		-	Ç.	elf Em	nlowed
\sim	- La -		17. Father's Name (First, Mic	(dlo (act)	4+		1115	irance c			e (First, Middle, I			proyed
lanc	uld be fi Mental P rked of tic ever	To Be	Patrick J.		ing						ine Deve			
Maryland 21215-0036	nd 2 sho alth and A 27 is ma r trauma		19a. Informant's Name/Rela Christine B			ey/nie					N. Bari			
Baltimore,	permit. Pages 1 and 2 should be filed Deperment of Health and Mental Hyg Important: if item 27 is marked othe eny injury or other traumatic event, ODGE.		20a. Method of Disposition 1 ☐ Burial 2 ☑Crema 4 ☐ Donation 5 ☐ Oth			ate	cemetery, crei	sition (Name of natory or other p ke Crema			Date 25-2006		on - City or T tsvill	
Balti	permit. Depertricularity Imports eny inju		21. Signature of Funeral Ser	vice Licens	2 mai 3	58	22	Name and Add Rapp Fu 933 Gis	ress of Facil ineral	& Cr Silv	emation er Spri	Servi	ice 20910	
			23a. Part1. Enter the diseas shock, or heart failure.	e, or comp	lications that cau	sed the dea	th. Do not ent							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Elot only o		otroph	ic La	teral So	leros	is			1	1 Death year
	/Medical		resulting in death)		Due to (or	ras a consec	quence of):							
	Examiner		Sequentially list conditions,		b									
	sit ed	lue	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury	~	Due to (or	as a consex	querios ut):							
_	xecut and Il-tran	Examiner	that initiated events resulting in death) Last	1	c	r as a conse	quence of):				• • • • • • • • • • • • • • • • • • • 			
8760,	cate be executed physicien and the burial-transit	ᄪ		ı			,							
687	ficate phys s the	edical			d									
.O. Box	In the death certificate be executed by the ettending physticien and tached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 Yes 2 No 9 Unknown	t :		h 2 ☐ Fetantatime of o	aldeath 3	Ectopic pregna Other (specify)				23d.	Date of deliv Month	ery Day Year
<u>α</u>	gned be de	þ	Part II. Other significant co	nditions co	entributing to dea	th but not re	sulting in the u	nderlying cause	given in Part	1.	23e. Did tol			the cause of death?
Ö	w requir been si should	etec												
	The lay ate has page 2	Completed									24a. Was a autops perform	SV	prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of 2 No
/ita	Physician: this certific ral director,	Be	25. Was case referred to me examiner?	-	(1						h (Check only on			
) t	Physic this c	ို	1 ☐ Yes 2€ No				ER/Outpatier				me 5 Reside			fy)
	ding After fune	atlon:	2 Accident in	ending vestigation	28a. Date of (Month,	Day Year)	28b. Time o Injury		ijuryat Vork? □Yes 2□		28d. Describe ho	ow injury oc	curred	
Division	el or Attendests after desti	Certification:		ould not be etermined	286. Place 0	f Injury - At h g, etc. <i>(Speci</i>	nome, farm, st ify)	reet, factory, office	Э		28f. Location (St City or Town		umber or Run	al Route Number,
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in the Funeral Director of the Funeral Dire	Medical			/sician: To the b iner: On the bas and manne	is of examin								
	To the within 2 To the comple	ž	29b. Signature and title of c	ertifier				29c. Lice	ense number	- / -	2		gned (Month,	
	9		> YVX	wh	JU				MD035	045		05-2	4-2006	
•			20 11	-		_								
	10		30. Name and address of pe Dr. Philip		ompleted cause im 1810				. #200	Olne	ey MD 20	832		

			1- For Amend Item 21 State of Amend Item 25 per Di	Mardass, Osp R	267060th Hertificate of I	lealth and Me	ental Hygi	ene g. No. 2 0 0 6	16585
	Physici		1. Decedent's Name (First, Middle, Last)	2. +lex			2. Date of Death Month		3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number of Social Security Number of Sex 1 M 2007 F	er) Compart House Age (In yrs. last birthday Yrs.	6len	Location of Death AM If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Feb. 14.	Year) Co	hplace (State or Foreign
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	Location		1.66, 19)	IYES MA	10d. Inside City Limits
	e Maryl	ctor	MD Baltimore	Glen	Arm				1 □Yes 2 XNo
	with th	I Dire	10e. Street and Number 11630 Glen Arm Road		10f. Zip Code 21057	7	10	g. Citizen of What Co	untry?
900	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. If marked other then "neturel; or items 23a or 28e-1 show item 27 is marked other then "neturel; or iteminar roust be notified at other treumetic event, it is Marical Examinar roust be notified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Norried 12. Was Decede Armed Force 1 Yes 2	es? X No	B. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
21215-0036	within 72 h lene. then "netu re Medicel	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40)	(Giv	redent's Usual Occupa re kind of work done of DO NOT use retired	turing most of working	7 1	6b. Kind of Business/	Industry
d 21	filed withi Hygiene. Sther then		12 none 17. Father's Name (First, Middle, Last)		Security	Officer 18. Mother's Name (Western El	ectric
Maryland	should be ind Mental I	To Be	Edward J. McCall			Lillian		aloen Sumame)	
Man	d 2 sho th and 1 7 Is mu treume		19a. Informant's Name/Relationship (<i>Type, Print</i>) Sue Verdecchia/Goddaughte		iling Address (Street a			City or Town, State, Z	(ip Code)
altimore,	000		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Sta 4 Ponation 5 Other (Specify)	20b. Place of Disp		Da		Oc. Location - City or	Town, State
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee Ronald S. Wade, Direct	tor per S	22. Name and Addres State Anato Baltimore,	my Board,	655 W.	Baltimore	Street
	Physician /Medical		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Due to (or	sed the death. Do not e	nter the mode of dying	g, such as cardiac or			Approximate Interval Between Onset and Death
8760,	Examiner sician and burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequence of):					
O. Box 6	at the death certificate be executed by the attending physician and trached for use as the burial-transit	Physician/Medical		1 2 ☐ Fetal death 3 tat time of death 5	☐Ectopic pregnancy			23d. Date of deli-	very Day Year
<u>Q</u> _	uires that signed b	by	Part II. Other significant conditions contributing to death	t but not resulting in the	underlying cause give	n in Part I.		cco use contribute to	the cause of death?
al Records,	ien: The law requires that the rtificate has been signed by th stor, page 2 should be detache	Completed					24a. Was an autopsy performs 1 \(\text{Yes} \) 2	prior to c	topsy findings available ompletion of cause of
of Vital	Physic r this ce ral direc	n; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No		of 28c. Injury	at 28		ce 6 □Other (Spec	ify)
Division	or Attending after death. Director: Afte in by the fune	Certification:	Accident investigation 3 Suicide 6 Could not be determined 28e. Place of	Injury - At home, farm, s	M 1 1 1	′es 2□No	f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
L-I	Hospitel 4 hours a Funerel tely filled	edical Ce	29a. Certifier (Check only one) 27 Medital Examiner: On the basis and manner and manner	s of examination and/or i	ath occurred at the tim investigation, in my op	e, date and place, and inion, death occurred	d due to the cau at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
1	To the within 2 To the complet	Me	29b. Signature and title of certifier	a Forpo la	29c, License	number 2 2	290	I. Date signed (Month)	Day, Year)
ć	20		30. Name and address of person who completed cause of	f death (Item/23a)	ZEROL	ina Ge	050 RUA	B #12°	7 BAUD my 21224
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 6 2006	strar's Signature	W.				

			1 _ State	State of Marylan		artment of He		ental Hygie	200	6 16586
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		WILLIAM	D BEA	ZKE	Y		MAY 2	3 06	11:59 p.M
þ	Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or		,_/	4c. County of De	alh
			5. Social Security Number 6. Sex	7. Age (In yrs. I	ITER		If Under 24 Hrs.	O Date of Diets	9 B	irthplace (State or Foreign
	Funeral Director			M 2 F 8	/ Yrs.	Months Days	Hours Min.	Sept 23	1924	Musculant
	pu »		Usual Residence of Decedent 10a. State 10b. County	100 Cin	, Town or L	nesting				10d. Inside City Limits
	death with the Maryland rma 23a or 28e-f ahow r.must be notified at	ō		100. 019	_	LTIMOR	· F			1 Yes 2 No
	28e-	Director	MARY AND 10e. Street and Number		Divi	10f. Zip Code		10g.	Citizen of What (Country?
	th with	al Di	6130 O'DENNE	in Street		212	24		U.S	A.
	r dea	Funeral		2. Was Decedent Ever in U. Amed Forces?	S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
36	filed within 72 hours after death with the Marylar Hygiene. the than - ith the Madical Examinat mast he notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	Uhite
5-0036	"natural", or	ted	15. Decedent's Educ	ation	16a. Dece	deni's Usual Occupa	tion	168	o. Kind of Busines	s/Industry
215	ithin 7 nen "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done do DO NOT use retired)		,	(a	netery
2	led wi tygien her th	Co	17. Father's Name (First, Middle, Last)		3	uperINT		(First, Middle, Mai		CTERG
anc	d be f	To Be	Fre And K	Nelson	B	erkev	CArri	- A.	oen samane,	Fischer
Maryland	shoul ind Me mark	F	19a. Informant's Name/Relationship (Typ			ing Address (Street a	nd Number or Rura	I Route Number, C	ity or Town, State,	Zip Code)
	end 2 Belth a n 27 is		WILLIAM D. BERKEY		364				smore 1	1D Z1229
ore	Pages 1 nent of He int: if iten		20a. Method of Disposition 1 Burial 2 Cremation 3 Re	moval from State		osition (Name of matory or other place)		c. Location - City o	
altimore,			4 Donation 5 Other (Specify) 21. Signature of uneral Service License		UE !	ridge Co	M.MAY3	2006	hurmont	MARYLAND
Ba	permit. Depertr Importa any infi		21. Signature a Tuneral Service License	3	-	Toseph N	ZAN	NINO J	T. Fun	MDZ1224
			23a. Part . Enter the disease, or complied shock, or heart failure. List only on	ations that caused the death	h. Do not en	ter the mode of dying	, such as cardiac o	espiratory arrest,	DHIE	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ACUTE					E	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):					
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Lt.	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events		·					
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929280	cate be executed physicien and the burial-transit	dicai	d							
W.	ding I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna	incy				23d. Date of d	elivery
m	death e etter	Iclar	in the past 12 months?	1 Live birth 2 Fetal		□Ectopic pregnancy □ Other (specify)			Month	Day Year
<u>о</u>	at the I by th	Phys	9 Unknown	9□ Unknown						
Vital Records, P.O. Box	Physician: The law requires that the death certifice this certificate has been signed by the ettending rail director, page 2 should be detached for use as	É	Part II. Other significant conditions con	,	uiting in the i	underlying cause give	n in Pari I.			to the cause of death?
000	w requ been shouk	etec	777					24a. Was an		aulopsy findings available
Bě	The tay te has age 2	Completed						autopsy	prior to death?	completion of cause of
ā	ian: intifice ctor, p	Be C	25. Was case referred to medical examiner?	/		- m	26. Place of Death	V	10 10	35 2 140
	hysic this ce	၉	1 □ Yes 2 No		ER/Outpatie		4 U Nursing Hor	ne 5 Residenc		ecify)
no	ding P. After funer	tlon	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? 'es 2 □No	28d. Describe how	mjury occurred	
Division of	Atten r deat ector: by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	ome, farm, st			28f. Location (Stree City or Town, S	t and Number or I	Rural Route Number,
۵	rs after or salter or all Dir	Cert		building, etc. (Specify					THE STATE OF THE S	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	Medicai	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, dea tion and/or i	th occurred at the time envestigation, in my op	e, date and place, a inion, death occurr	and due to the caus ed at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)
	outhin to the	Mec	29b. Signature and title of certifier	and marrier stated.		29c. License	number	29d.	Date signed (Mor	nth, Day, Year)
•			* KRNOC	lolokia	MI	D006	3326	м	AY,Z	4.06
	10		30. Name and address of person who cou	mpleted cause of death (Item	n 23a) (Type					
	Sta	ata	30. Name and address of person who con KUSH-R-DHOL 31. Date filed (Month, Day, Year)	AKIA, MD 1	YEK C	- 7 MEDIC	AL CEI	UIER,E	SHLTIKO	RE, MD
4	Regist		MAY 2 6 2006	Serve &	Con	W.				

Please Type or Print in Black Indelible Ink

Robert John Burdess, 4th

State of Maryland / Department of Health and Mental Hygiene 2006 | 6587 Certificate of Death

		For State											Reg. I	No.	UU		1000
Physician	1. Decedent's Name (First, Middle, Last)											Date of D Month	Da		аг	3. Time of 0620	
Medical Examin		Robert Joni						4b Ci	ity, Town, or	Location		May 24,	2000	4c. County	of Death	0020	
		704 Court Square Driv		(reet and no	annoci /				lgewood					Harford			
Funeral	5	5. Social Security Number	6 Sex		7. Age (I	n yrs. lasi	t birthday)	_	Under 1 Yea	_		8 Date of	Birth(N	MM/DD/YYYY			ate or
Director	1	04-72-3103	1 X N	2 F		28	Y		onths Day	s Hours	Min	July	10,	1977	Foreigi	intry) NC	
	ι	Jsual Residence of Decedent												· · · · · · · · · · · · · · · · · · ·			
, any		10a State 10b. County			10	c. City, T	own or Loca	ation									e City Limits s 2X No
land f shov	ēΜ	aryland Harfo	ord		I	Edgev	vood	1.00	7: 0 !				1.0-	Citizen of W	\ C		3 24 110
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 704 Court Squa	3 2 0	Drivo					Zip Code 21040				_	ISA	iat Cour	ili y ?	
ith the 23a o		11. Marital Status		12. Was De		er in IIS	113 W		cedent of Hi	spanic Orio	nin? (Spec	ifv Yes or			- Amer	can Indian,	. Black.
sath writems	<u> </u>		arried	Armed F	orces?	3			pecify Cuba						e, etc.		
fter de		3 Widowed 4 Div	orced If	1 Yes Yes, Give Ye or Dates:		No	1	Yes	₹ No	specify				Specify	Wh:	ite	
ours a atura	함	15. Decedent's Education (Spe			de comple	eted) 1			sual Occupa f working life				16	b Kind of B	ısiness/lı	ndustry	
6 n 72 h	Completed	Elementary/Secondary (0-12)		College (1-4 or 5+)		Electi							Union	1		
withi withi giene her th	티	17. Father's Name (First, Middle	Last)		_		-		1	18.Mother	's Name (F	irst, Middle	e, Mai	den Surname	2)		
21215-0036 uld be filed within 72 hours after Mental Hygiene marked other than "natural", cevent, the Medical Examiner.	Bec	Robert John B		ss II	I					Hele	en Mai	cie T	rey	•			
re, MD 21219 Land 2 should be fill Fleath and Mental F fiten 27 is marked or traumatic event, t	2	19a. Informant's Name/Relations												r, City or Tov)
MD 2 and 2 shou lealth and N tem 27 is n traumatic		Robert Burdess	III	/ Fa	ther	Lan e								, Md.			
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene unt: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 Burial 2 Cremation	n 3	Removal f	rom State	Cre	ematory or	other pl				Date		0c. Location			
Page Page ment c	L	4 Qonation 5 Other S	pecify.			Hill			rice C					lowson,			
Baltimore, permit Pages I ar Department of Hee Important: If ite		Signature of Funeral Service		7				1000 217	mas F	unera	I Hon	ne, P	.A.	don, N	larv.	land	21009
Physician	+	MULLU II MY 23a. Part I. Enter the disease of	comple	ations that	caused th	e death. [Do not ente	r the me	ode of dying	, such as o	ardiac or r	espiratory	arrest,	shock, or he	art	Approxi	mate Interval
/Medical		failure_List only_one cadse onleach line. Immediate Cause (Final diseasea Hanging													n Onset and Death		
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	nine	if any, leading to immediate cause. Enter Underlying Cause		ue to (or as	a consequ	derice or,											
, / p .ts	Examine	events resulting in death) Last	D	ue to (or as	a consequ	uence ot)											
760, Crate be executed g physician and the burial - transit	ledical	UNPENDED	մ Ծ	AMENDED	16h	10h	por	fh d	g855 !	5-26-	06 vrt						
3760, ficate be e g physicia s the buria	Jed i	IF FEMALE:	24	23c. If yes				.11	6077 .		OO VL		_	23d Date of	f deliven		
876 rtiffcate ing phy as the	2	23b Was decedent pregnant in t past 12 months?	he	1 Live	birth		2	Fetal de	eath 3	Ectopi	ic pregnand	СУ		Month		Day	Year
Box 68760, re death certificate by the attending physic ned for use as the but	Sicis		known		nant at tir	ne of dea	th 5	Other	(Specify)								
P.O. Boxes that the death gigned by the atte	Physicial	Part II. Other significant condi	tions (9 Unki		out not res	sulting in th	e under	rlying cause	given in P	art I.	23e. Di	id toba	cco use cont	ribute to	the cause	of death?
P.O s that	ā											1	Yes	2 V No 3	Prot	pably 4	Unknown
ds, equire een si	eted							-				24a W		24b.			ngs available of cause of
COF	Completed											pe	utopsy erforme es 2		death?		2 No
Reiffcate		25 Was case referred to medic	al I				<u> </u>		26.Plac	ce of Death	(Check or	£ 3	3 2		[V] 10		
Vital Records, P.O. B systeian: The law requires that the discertificate has been signed by the director, page 2 should be detached	o Be	examiner?	_	spital: 1	Inpatient	2	ER/Outpatie	ent 3	DOA	Other ₄	Nursing	Home 5	Re	esidence 6	✓ Othe	r: Scene	
Division of Vital Records, P.O. tat or Attending Physician: The law requires that the safer death al Director: After this certificate has been signed by fled in by the funeral director, page 2 should be detach	-1	27. Manner of Death		28a. Dat	e of Injury th Day Yea 4, 2006	r ar)	28b. Time o	of Injury	/ 28c. Inj	ury at Wor		8d Descri		w injury occur	red		
Sion Attendir death ctor: A	aţio		nding estigatio		4, 2006		0000 hrs		1	Yes 2 ✓	No						
ivis or At after d Direct lin by	Certification:	3 V Suicide 6 Co	uld not b	e 28e. Pla		•	me, farm, s	reet, fa	ictory, office	building, e	tc 28f Location (Street and Number or Rural Route Number, City or Town, State)						
Divis ospital or A hours after uneral Dire	Se	4 Homicide	ermined		y) resid							or Town, State) 704 Court Square Drive, Edgewood, MD nd due to the cause(s) and manner as started					
로 첫 독 필	ical	(Check only one) 2 Medical Ex	Physicia aminer:	n: To the b On the basi	est of my s of exami	knowledg ination an	e, death oc nd/or investi	curred ; gation,	at the time, in my opinio	date and p on, death o	ccurred at	the time, d	ause(s late an	s) and manne d place, and	or as star due to th	ted ie cause(s))
To the within To the complete	Medical	29b. Signature and title of certif		and manner						nse numbe				29d Date sig			
		Dt A		_(200	2.4	~		0.0	.M.E.				May 25, 2	006		
		30. Name and address of person	on who c	ompleted ca	use of de	ath (Item	23a)		1								
3	. 0	Patricia Aronica-Poll		. Assis	stant Me	edical E	xaminer		1 Penn S	Street, B	altimore	, MD 21	201				
	tate	31. Date filed (Month, Day Year	Date filed (Month, Day Year) 2 6 20 6 20 6 January Jacobs														
Regis	trar	RITA I	~ 0	-040	100	P. Park	6 4										

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Jeffrey Grant Bennett Certificate of Death 1- For State Reg. No 2. Date of Death 3. Time of Deat Decedent's Name (First, Middle, Last) Physician/ May 21, 2006 1224 hrs Medical Examiner Jeffrey Grant Bennett 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number Darlington Harford 1639 Poole Road If Under 1 Year | If Under 24Hrs. 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY) 7. Age (In vrs. last birthday) Social Security Number 6 Sex Funeral Foreign Country) Maryland Months Davs Hours Director 220-76-7947 48 Mar. 2. 1958 1 X M 2 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No 28a-f show Bel Air Maryland Harford notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21015 USA 3018 Lochary Road Funeral 14. Race - American Indian, Black 11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Armed Forces? 2 Married 2 X No Yes f Yes, Give Year 1 Yes 2 X No specify: Specify 3 Widowed 4 Divorced White ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the Medical Baltimore, MD 21215-0036 Tractor Trailer Driver Freicht Company 10 and Mental Hygiene 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be (unk) Bennett Mabel Emolene Warden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P traumatic 27 is Sarah L. Tomalonis / Girlfriend 3018 Lochary Road, Bel Air, Maryland 21015 other trau 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Harford Memorial Grdrs 5-26-06 Aberdeen, Maryland Important: Donation 5 Other Specify 0. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Between Onset and Physician failure. List only one cause on M-dica Contact Gunshot Wound of Head Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): cal UNPENDED AMENDED Physician/Medi 68760 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy as the b 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Box 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö by 1 Yes 2 No 3 Probably 4 Unknown Δ. Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No page 26.Place of Death (Check only one) 25. Was case referred to medical director, Be Other₄ Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 Other: Scene DOA ER/Outpatient 3 1 V Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work' 28d. Describe how injury occurred 28b Time of Injury 27 Manner of Death Subject shot self Certification FOUND: Natura Yes 2 🗸 No 5 Pending death. Fo the Funeral Director: May 21, 2006 1224 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City after 3 V Suicide Could not be or Town, State) 1639 Poole Road, Darlington, Md. determined (Specify) Single Family Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) M O.C.M.E May 22, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Mon AAY, Year) 6 2006

gistrar's Signature

the series

06-03523 Ch

-03523		Please Type or Print in Black Indelible Ink			
niranjit Bose		State of Maryland / Department of Health and Mental H	ygiene	200	0 1050
	- 1	1- For State Certificate of Death Registrar		. No. 200	
Physiciar		1. Decedent's Name (First, Middle,Last) Chiranjit Bose	Date of Death Month I	Day Year	3. Time of Death 1452 hrs
41 Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	May 24, 200	J6 4c. County of Death	
		233 South Bouldin Street Baltimore	1	N/A	1
Funeral	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	s 18 Date of Birth	(MM/DD/YYYY) 9. Bir	tholace (State or
Director		Months Days Hours Min		Foreig	
	-	Z14-80-7896 1 XM 2 F 04 Yrs. Usual Residence of Decedent	riay 3	, 1342	unity) IIIGIA
any	Ì	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	_	Maryland N/A Baltimore			1 X Yes 2 No
re Maryland or 28a-f show fied at once.	Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cou	ntry?
ith the Maryland 23a or 28a-f sho		233 S. Bouldin Street 21224		Indi	.a
ms 2.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black,
or ite	띪	Yes 2 X No	o recen, etc.,	,	on Indian
s after	ক্র	3 Widowed 4 N Divorced If Yes, Give Year 1 Yes 2N No specify:			an Indian
136 thin 72 hours at re. than "natural calical Examin	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or		16b. Kind of Business/	Industry
36 hin 72 e. than	림	5+ Stationary Engineer		Hospita	1
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21215-0036 ould be filed within 72 d Mental Hygiene. s marked other than " ite event, the Medical.	Be	Mohini Mohan Bose Malaya	a Rani Gh	osh	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f she rether traumatic event, the Medical Examiner must be notified at once.	ျ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or			
and 2 short and 2 short		Subid Bose, Brother 17 West End Circle Ha		·	
of Heal	-1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
		4 Donation 5 Other Specify: Metro Crematory Inc. 05/	/26/06	Baltimore	, Maryland
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	-8	Thomas Gregor 299 Frederick Roa 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate Interval
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n of ling Ph After 1 funeral		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 ✓ Natural 5 Pandias	28d. Describe ho	ow injury occurred	
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be the Funeral Director: After this certificate has been signed by the attending physic upletely filled in by the funeral director, page 2 should be detached for use as the buri		4 Homicide (Cartifier)	1	(a) and	
Divis To the Hospital or A within 24 hours after To the Funeral Dire	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred			
To T	Mec	and manner stated. 29b. Signature and title officertifier 29c. License number	Т	29d. Date signed (Mo	onth, Day, Year)
		O.C.M.E.		May 25, 2006	
119		30. Name and address of person who completed cause of death (Item 23a)			
4 '		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201		
Sta	ate	31. Date filed (Month, Day, Year) MAY 2 6 2006			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink 06-03509 State of Maryland / Department of Health and Mental Hygiene Patricia L. Brodsky 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 24, 2006 Medical Examiner Patrisha Lynn Brodsky 1c County of Death 4b City Town or Location of Death 4a Facility Name (if not institution, give street and number) Randallstown **Baltimore County** Northwest Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7 Age (In vrs. last birthday If Under 1 Year **Funeral** Months Days Hours Director 1 M 2 **X** F 05/05/1989 212-25-7970 Usual Residence of Decedent 10c. City, Town or Location Auk 10a State 10h County 28a-f show or items 23a or 28a-f sho must be notified at once. Owings Mills MD Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland nem of Health and Mental Hygiene. Director 10e. Street and Number 104 Pinemere Road 21117 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married 2 Married 2 X No Yes "natural", or f Yes, Give Year 1 Yes 2 X No specify Divorced Specify: 3 Widowed ð r Dates 16a Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Flementary/Secondary (0-12) narked other than " MD 21215-0036 Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked Be Daniel A. Brodsky, Sr. 19a Informant's Name/Relationship (Type, Print) Tracy D. Brodsky If item 27 Mother 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date X Burial 2 Cremation 3 crematory or other place) Removal from State Important: Donation 5 Saints' Cemetery 5/30/06 i Signature of Funeral Service Licenses 22. Name and Address of Facility Eline Funeral Home 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician failure List only one cause on each line /Medical a Asphyxia by hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical UNPENDED AMENDED death certificate be Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy 23b Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ð σ. Completed Records, 24a. Was an performed? Yes 2 26 Place of Death (Check only one Physician: 25. Was case referred to medical of Vital Be examiner? Other; Hospital. 1 Inpatient DOA 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes 28a. Date of Injury FOUND: 28d. Describe how injury occurred 28b Time of Injury 28c Injury at Work? 27 Manner of Death Subject hanged self FOUND: Natura! 1 Yes 2 ✓ No Pendina

10d Inside City Limits Yes 2 X No 10g Citizen of What Country 14 Race - American Indian Black White, etc. White 16b. Kind of Business/Industry N/ATracy Delphine Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Pinemere Road, Owings Mills, MD 21117 20c Location - City or Town, State Reisterstown, 11824 Reisterstown Road Reisterstown, Between Onset and Death 23d Date of delivery Year Day 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available death? No 1 V Yes Other Hospital or Attending Certification: Division May 24, 2006 0630 hrs Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be 104 Pinemere Road, Owings Mills, MD (Specify) Single Family To the Funeral Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. May 25, 2006 6 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Da 2 Year) State 6 Registra ORIGINAL DHMH 17 Rev 1/2001 OCME 2006

0727 hrs

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Country)

Diane Louise Bosetti	Charles Type or Print in Black Indelible Ink
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21215-0036 hould be filed within 7 md Mental Hygiene is marked other than rife event, the Medica	l a	Louis C. Bos					Barbara	Hurle	Maiden Surname V))		
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To the within 7 To the complet		Medical Examin	ician: To the best of er:On the basis of ex	amination and/or	r investigation,	at the time, date and in my opinion, death	I place, and due to noccurred at the t	o the cause(s	s) and manner as	started.		0
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		anelz	*			O.C.M.E.			9d Date signed		y, Year)	
10 read	3	0. Name and address of person who	completed cause of	death (Item 23a))				May 23, 200€ 			
DLI	17	Ana Rubio MD. Assist:	ant Medical Exa			et, Baltimore, M	ID 21201					
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DHMH 17 Rev 1/2001 OCME 2006

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State Registrar

	•	For State Registrar	31	iale of	iviai yiai		ertifica		ealth and N D <i>eath</i>	nental Hy	/gien Reg. N	401	06	1659
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/Medica Examine		4a. Facility Name (If not institut Levindale	on, give stree				4b. Cit	Balt	Location of Death			c. County		
Funeral Director		5. Social Security Number 214-36-6353 Usual Residence of Decedent	6. Sex 1 ☐ M		Age (In yrs. 67	last birthda Yrs	Month		If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Jan 3	ay, Yea	r) 939		lace (State or Foreig stry) y land
aryland show	_	10a. State 10b. Cour	•		10c. Ci	ty, Town or		2.4.7					1	0d. Inside City Limi
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should and Men is marke	၉	Robert Jord 19a. Informant's Name/Relation				19b. M	ailing Addre	ss (Street a	Regin and Number or Rui	a M. Ti		-	State, Zip	Code)
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To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	ation; T	27. Manner of Death 1 X Natural 5 Pen		8a. Date of		28b. Tim Inju	e of	28c. Injury Work	at	28d. Describe			. , ,	7
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		30. Name and address of pers	,		of death (Ite	m 23a) (Ty	pe, Print)	Ve	3767 Ave.	B 11	1 1119	727	2000	3
Stat Registra		31. Date filed (Month, Day, Ye	6 2001	32. H	gistrar's Sign	ature —	Angel .		ejive.	porte 17	, /	/4 2	1213	

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1:30pm_м Month Year Physician Caines Nancy May 20,2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Gaithersburg Wilson Health Care Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Feb. 5, 1917 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 M 2 F Months Hours 085-05-3475 89 New York, NY Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show ir than "natural", or Items 23a or 28a-f shov tre Medical Examinat must be notified at 1 Yes 2 □ No Gaithersburg MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20877 USA 301 Russell Avenue Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (★No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: Be Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hospital al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Medical Records Dept. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fit thent of Health and Mental H tant: If Item 27 is marked ott jury or other traumatic even Gaetano Melay Salvatore Roccuzzo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3939 Ivy Terrace Court NW Washington, DC 20007 Marjorie Chirikjian / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 24, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State permit. Page Department o Important: If any injury or once. Assumption Cemetery 2006 New Egypt, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave. Baltimore MD 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, o shock, or heart failure. Lin complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) marordial Sminules Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Superturken 3 ☐ Probably 4 ☐ Unknown zalastiriles. 1 ☐ Yes 2 ☐ No Completed nileaged aleir Vilamen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 310 heigh needle path View. 20 Division of Vital 26. Place of Deat Check only one 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 Ø No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: I or Attending Patter death. After Injury 5 Pending investigation 1 V Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1004115 IL Robert Disselber May 21, 2006 (ull) 201 RUSSELL AVENUE 30. Name and address of person who completed cause of death (Item 23a) Type, Print) GALTHERS BURG, H. ROBERT BIRSCHBACH, NI,D 31. Date filed (Month, Day, Year) 32. Aggistrar's Signature State MAY 2 6 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 17 per fh 8856 6-5-06 vt.
State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 22 Month Month andndge **Physician** 3:46 ,0M orothu /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital Flanes If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug: 3,1909 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 215-18-7126 Days Hours 1 M 2 TF Months Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene.
Item 27 ie marked other than "natural", or Iteme 23a or 28a-f ehow other treumatic event, the Medical Examinar must be notified at Batte 1 Yes 2 No Director mo 10e. Street and Number 10g. Citizen of What Country? hoice USA 601 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubán, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Hospitalo College (1-4or 5+) gistere 3 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumame) Be Catlin ပ္ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 ie eny injury or other treu 1013 -daughter Jo sepha Snead Wildwood PKuy 20b. Place of Disposition (Name of 20a. Method of Disposition Date 204. Location - City or Town, State Parkuvo or other place) 1 2 Surial 2 Cremation 3 Removal from State -30-06 4 □ Donation ☐ Other (Specify)

21. Signature of Juneral Service Lutens Down 22. Name and Address of Facility 270 Fredition Pass P, march Freneral Home Balto, md, 21229 Approximate Interval Between Onset and Death 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or Andition resulting in death) SEPSIS Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of) ettending physician for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) cete hes been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ DEHYDRATION 3 Probably 4 DUnknown 1 ☐ Yas 2 ☐ No. Be Completed HYPOTHERINIA 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ŏ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 170 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0051865 MAY 22, 2006 Lle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MESPITITE URTES BATTIMORY IM CMITCHES 51 17612125 31. Date filed (Month, Day, Year) MAY 2 6 2006 32. Registrar's Signature State

Registrar

Sandridge,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené 1 - For Stete Registrar Certificate of Death Reg. No. t's Name (First, Middle, Last) 2. Date of Death DURKIN 22-06 4b. City Town, or Location of Death Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number Days Months 126-03-8225 1 ☐ M 2 🔀 F 87 May 8,1919 Buffalo, NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Crofton 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1410 Kensington Place 21114 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: lf Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Patrick J. Meegan Bridget A. Murry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Lobue / Daughter Kensington Place Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 27, Lackawanna, NY Holy Cross Cemetery 4 ☐ Donation — 5 ☐ Other (Specify) 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave Baltimore MD 21230 21. Signature of Funeral Service Licensee or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one caused each line. 23a. Part 1. Enter the disease, shock, or heart failure. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nnknown

Physician /Medical Examiner

Physician

/Medical

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28a-f show

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Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital

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death

Examiner burial-transit and attending physician Physician/Medical the the a þ Completed been certificate has 2 this Certification; After Hospital or Attending 24 hours after death.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

24a. Was an rmed2 2 No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

1 Natural 2 Accident

29a. Certifier

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28b. Time of Injury

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

2 🗌 No

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

1 Tyes

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

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MAY 2 6 2006



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24 hours after deatle Funeral Diractor:

To the within 2

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portition is with yield yield at 12.13.0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event, the Medical Examinar must be notified at once.	ō	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
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g.	Sta Registr	te ar	31. Date filed (Month, Day	2 6 201)6 32 Aeg	ASTERN gistrar's Signal	ture	entir								

Taemiea Forrester

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink

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State of	Maryland /	Department	of Health	and Mental	Hygiene

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		- For State			Certific	cate of L	Death			Re	eg. No.	UUI	0	1007
Physicia edical Examin	n/	1. Decedent's Name (First, Mi	Denia	- Fo	rres					Date of Dea Month May 21, 2	Day Ye		3 Time of 0340	
		4a. Facility Name (if not institu University Hospital	tion, give street ar	nd number)			City, Town, or Baltimore C		f Death		4c. County	of Death		
Funeral Director		5. Social Security Number	6. Sex		In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days		Min	8. Date of Bir	31,2003	Y) 9. Birth Foreign Cour		Md)
эм ану	- 1-	Usual Residence of Decedent 10a. State 10b. Coun	NIA	10	C. City, Tow							1		e City Limits
with the Maryland s 23a or 28a-f show a e notified at once,	Director	10e. Street and Number	177	•	<u> </u>	timo	10f. Zip Code	21/		1	0g. Citizen of W	hat Countr	ry?	
ath with the items 23a o	— L	11. Marital Status	Married Arm	s Decedent Ev	1		Decedent of His specify Cuban		in? (Spec		- 14. Race	e, etc.		Black,
hours after de "naturat", or	출.	3 Widowed 4 15. Decedent's Education (S	Divorced If Yes, Giv		`		es 2 No		ind of wor	k done	Specify:			
5-0036 Hod within 72 hours after death with the Maryland Bygene other than "natural", or items 23a or 28a-f shi the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-1		ege (1-4 or 5+)			t of working life.				N	1 _A	ĺ	
215- be filed mtal Hyg rked off	Be	17. Father's Name (First, Midd Michae	1 G.		25te			Tier	ra	S.	Maiden Surname	hord		
MD 2 d 2 should Ith and M n 27 is m	ို	19a. Informant's Name/Relation	onship (Type, Print am pto N	/	الما الما	96. Mailing A 2406	Wwche	t and Numb	ber or Rur	al Royte Nun	Baltin			21216
More, Neges Land hen of Health ant: If item or other trau		20a. Method of Disposition 1 Burial 2 Crema	tion 3 Remo	oval from State		atory or other			5/2	Date /	20c. Location	- City or To		Md
Baftin permit P Departme Importan injury or		4 Donation 5 Other 21. Signature of Funeral Serv			IV SEC	22. Nar	me and Address	of Facility	Cha	bman-	- Harris	Fun	recal	
Physician	1	23a. Fart I. Ent. the disease, failure. It only one cau		that caused the	e death. Do r						est, shock, or he			nate Interval
/Medical Examiner	-	Immediate Cause (Final disea or condition resulting in death	ase a Head In	njuries r as a consequ	uence of):									Death
	ē	Sequentially list conditions, if any, leading to immediate		r as a consequ	uence of):							-		
it. e d.	Examine	cause. Enter Underlying Cau (Disease or injury that initiate events resulting in death) La	d C.	r as a consequ	uence of):							\rightarrow		1
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8760, ificate be every physician as the burial -	뒴	IF FEMALE: 23b. Was decedent pregnant i	23c. lf	yes, outcome	of pregnanc	У)				23d. Date of Month	•	ay	Year
D.O. Box 68. That the death certifined by the attending detached for use as it	Physicia	past 12 months? 1 Yes 2 No 9	4 🔲	Pregnant at tin Unknown			r (Specify)		-		1			
ires that the signed by the detached	by Ph	Part II. Other significant con	ditions contribu	ting to death b	out not resulti	ing in the und	derlying cause o	given in Par	rt I.		obacco use contr			
rds, l	Completed									24a. Was	an 24b.	Were auto	opsy findir	ngs available of cause of
of Vital Records ing Physician: The law requir After this certificate has been uneral director, page 2 should		25. Was case referred to med	lical I				26 Place	of Death (Chook on	1 Yes		death? Yes	2	No No
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pm — —	ation: T	27. Manner of Death 1 Natural 5 P	ending 28a. Ma	Date of Injury (Month, Day Year y 20, 2006	28b 203	o. Time of Inju 31 hrs	·	ry at Work? ∕es 2 ✔	lp,	8d Describe edestrian	how injury occur struck by au	red to		
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Divisior To the Hospital or Attend within 24 hours after death To the Finteral Director completely filled in by the	Medical (Physician: To the background markers											
F \$ F 0	Ĕ	29b. Signature and title of cer	tifier				29c. Licens O.C.				29d. Date sign May 22, 20		h, Day,Ye	ear)
\		30. Name and address of per Ling Li, MD Assi	son who completed				Baltimore,	MD 2120	01		1			
St. Regist	ate rar	31. Date filed (Month, Day, Ye	ar)	32 Registrar's	Signature	Book	7							
DHMH 17 Rev 1/20	001	MAIN	2000		Ó	RIGINAL								

SEE: DIANA BARBOUR

Theresa Foster 2006 16600

07/07/11 - Wrong info typed in State
5-22/State
anatomy Rd.

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month 23^{Day} **Physician** 2006 May Alvin Elwood Flickinger 12:30 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery General Hospital 01ney Montgomery | House | Hours | Hours | Min. | B. Date of Birth | Month, Day, Year) | December | 20, 1916 | Pennsylvania 5. Social Security Number 6. Sex 1. 1 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 89 577-05-3490 Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits and Mental Hygiene. Is marked other than "natural", or Iteme 23e or 28e-f show raumatic event. The Medical Examinar must be notified at 1 Yes 2 No Maryland Montgomery Derwood Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5612 Foggy Lane 20855 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritaf Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Meat Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alvin J. Flickinger Mary Musselman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau once. Hilda S. Flickinger/Wife 5612 Foggy Lane, Derwood, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service Licensee Mullian M01173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** Sepsic /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, feading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tr Due to (or as a consequence of) .O. Box 68760, Completed by Physician/Medical attending for use as 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9☐ Unknown 9 Unknown ģ Division of Vital Records, P. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 Yes 2 No 1 🗌 Yes 252 No 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 npatient 2 ER/Outpatient 3 DOA this After the 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how intury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No death. neral Director; A filled in by the fe 2 Accident 6 Could not be 3 Suicide 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide after vithin 24 hours a 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0054 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1810 Prince Phillip drive olnow 31. Date filed (Month, Day, Year) MAY 2 6 2006 32. Registrar's Signature State Registrar

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		= State Registrar			Cei	rtificate	e of L	<i>Death</i>			g. No.	00	1000	(L.
		1. Decedent's Name (First, Middl	e, Last)						2	 Date of Deat Month 	h Day .	Year	3. Time of Death	
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Examine		4a. Facility Name (If not institution		riber)		4b. City,	Town, or	Location of	Death	9	4c. County	of Death		
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I			1 Year	If Under 2		. Date of Birth (Month, Day,			lace (State or Fore	ign
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	ı	Usual Residence of Decedent								45456 1	1,1200			
yland		10a. State 10b. County	•	10c. City	, Town or Lo	cation						1	0d. Inside City Limi	ts
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288 not	Director	10e. Street and Number	J. 10 House			10f. Zip				11	Og. Citizen of \	What Cour	itry?	
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iner of the co	2	1 ☐ Never Married 2 🏋 Mar	ned 1 ☐ Yes					n, Mexican,	Puerto Ri	can, etc.)	Blac	ck, White,	etc.	
21215-0036 Ind within 72 hours at giene. In then "natural", or it the Medical Expris	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes Gi	ve 11 lates:		1 Yes	2 X No	Specify:			Specify		hite	
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Baltimore, sering, Pages 1 a Department of Her mportant: If them any injury or other pages.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from	State State	emetery, crei	natory or o	ther place	3)				•		
Baltimor permit. Pages Department of Important: If it any njury or o		4 ☐ Donation 5 ☐ Other (5			Memor	ial P	ark	M	ay 26	. 2006_	Rockvi	11e,	Maryland neral Hom Avenue	
Balti permit. Deportu Importu any nji		21. Signature of Funeral Service	Licensee		22	Name an	d Addres	s of Facility	Robe	rt A.]	Pumphre	y Fui	neral Hom	e
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17,5171		23a. Part1. Enter the disease, o shock, or heart failure. List	conflictions that	aused the death	n. Do not ent	er the mod	le ol dying	g, such as c	cardiac or r	espiratory arre	est,		Approximate Interval Between	
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Physician / /Medical		disease or condition resulting in death)	a [4]	ute	16espi	tury	V.	ist res.	s Sy	ndrom	0		+ days	
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, pg ;;	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	4		301100 017.								71.	
and tran	кап	that initiated events resulting in death) Last		Gner's	uence ol):								1 cuiss	_
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deal deal	S	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of de		Other (sp				 	Mo	onth	Day Year	
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s tha	Y P	Part II. Other significant conditi	ons contributing to d	eath but not resu	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did tob	acco use cont	ribute to th	e cause of death?	
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hysi his c	၉	1 ☐ Yes 2 ØNo			ER/Outpatier			4 LI Nur		5 Reside			1)	
ng P	ü.	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury		8c. Injury Work	?		d. Describe ho	w injury occur	red		
Vision Attending If death. ector: After	ati	2 ☐ Accident invest	igation			М	1 🗆 Y	′es 2 □ N	10					
Vis rattr rect	₩	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 289. Place	of Injury - At ho		reet, lactory	, office		28	I. Location (Sti City or Town	reet and Numb	er or Rura	l Route Number,	
Hospital or to hours effe Funeral Directory filled in the hours effe	Certification:			3	,									
pspii hour ineri y filli	a	29a. Certifier 1 Certifyi	ng Physician: To the	best of my kno	wledge, deat	h occurred	at the tim	e, date and	place, an	d due to the ca	use(s) and ma	anner as st	ated.	
Division of To the Hospital or Attending Ph within 24 hours elter death. completely filled in by the funeral	Medical	(Check only 2 Medical one)	Examiner: On the band man	pasis of examina iner stated.	iion and/or in	vestigation	, in my op	mion, death	n occurred	at the time, da	ite and place,	and due to	ine cause(s)	
To the within 2 To the complete	ž	29b. Signature and title of certific	or a			290	. License	number		25	d. Date signe	d (Month,	Day, Year)	
		> IVI Vales	Physon	- A L		1	0630	18-0			Va	ond	2001	
		30. Name and address of person		JAN se of death (Item	23a) (Tuno		0 30	03		/	uy d	of	2006	
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e.		31. Date liled (Month, Day, Year	7,709.	Registrar's Signa		ат Се	nrer	DLTA	e voc	kville,	naryı	and 2	0000	
Sta Registr		MAY 9 G	#	A A		alle)								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 24, 2006 **Physician** 2:55 A. Carlyn Elizabeth Goss /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth | November | 12, 1919 | 9. Birthplace (Statement of Statement of Sta 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 KF 86 219-01-3068 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State or then "natural", or itame 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 1 No Timonium Directo Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2300 Dulaney Valley Road Apt. C106 21093 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 2:50 A.M. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry permit. Pages 1 and 2 should be filed within 2 Department of Health and Mental Hygiene. Important: If tem 27 is markad other then "na eny injury or other traumatic average. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Olga Nagle Carl Tormollen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1022 Jamieson Road Lutherville, Maryland 21093 Lawrence Goss/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Gardens of Faith 5/26/06 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Christina L. Hilton

22. Name and Address of Facility
Leonard J. Ruck, Inc.
5305 Harford Road Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner substitute of the state of the Due to (or as a consequent Examine attending physicien and for use as the burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 Other (specify) 4 Pregnant at time of death ed by the a 9 Unknown 9 Unknown certificete has been signed by rector, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2200 ၉ 1 🗌 Yes 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending To the mosper within 24 hours after death.

To the Funerel Director: All death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Praminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. Licease number 153 £ 25.06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) MAY 2 6 2006 32. Registrar's Signature State E SHOW Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 8 State-of, Maryland / Personnent of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** /Medical Town, or Lacation of Death and number 4b. City 4a. Facility Name (If not institution, give stree Examiner If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 02/09/1922 6 Sex 7. Age (In yrs. lagt birthdav) **Funeral** Davs Hours Min 1 □ M 2 1 Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 140 Completed by Funeral Director 10g. Citizen of What Country? 16f. Zip Code 10e Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. ant: If Item 27 Is marked other then "naturel", or Itams 23a or: 21220 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify 3 ₩idowed 4 Divorced Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last Be ဂ 19b. Mailing Address/(Street and Number or Rurat 19a. Informant's Name Relationship (nint) Department of Health a Important: If Item 27 Is eny injury or other tra ace of Disposition metery, crematory Date 20a. Method of Disposition Burial 2 Cremation B □ Bemoval from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility MERCE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Hypertensive Immediate Cause (Final arlenosclerotic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner lon cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed page 2 should be detached for use as the burial-transit failure resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 2□No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification; To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) in by 4 - Homicide filled 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD MD 61504 23/2006 Mo hand 3001 South Hanover Street, Ballimore, MD

State Registrar

1

31. Date filed (Month, Day, Year) MAY 2 6 2006

30. Name and addr

Mohanlal 32 Registrar's Signature

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Laurie Dee Hayden Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Laurie Dee Hayden 1629 hrs **Medical Examiner** LAURIE GHASSEMI May 23, 2006 4a Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Baltimore** 4904 Goodnow Road, Apartment K N/A 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs, last birthday) **Funeral** Foreign Days Months Hours Director 220-74-7777 47 02/22/1959 MD 2 X F Country) Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 1 X Yes 2 No BALTIMORE MD N/A 28a-f show notified at once. with the Maryland Director 10g Citizen of What Country 10e. Street and Number 10f. Zip Code 4907 GOODNOW ROAD 21206 U.S.A. 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black 12 Was Decedent Ever in U.S. 11 Mantal Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married Yes Widowed 4 X Divorced f Yes Give Year Yes 2 X No specify. Specify. WHITE Pages I and 2 should be filed within 72 hours after neut of Health and Montal Hygens and: If item 77 is marked other than "natural", and: If item 77 is marked other than "natural", or other traumatic event, the Medical Examiner. à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 FOOD PREPARER FOOD SERVICE 17. Father's Name (First, Middle, Last) 18 Mother's Name (First_Middle_Maiden Surname) Be SAMUEL GREENFELD SARAH LEITES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STANLEY GREENFELD/STEP-BROTHER 3733 GREENWAY LANE - OWING MILLS, MD 21117 20a Method of Disposition Place of Disposition (Name of cemetery Department of He Important: If ite injury or other to crematory or other place) X Burial 2 MOGAN ABRAHAM |05/25/2006| ROSEDALE, MD Other Specify Donation 5 22. Name and Address of Facility 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock Approximate Interva **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Quetia ine intoxication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last sician/Medical X UNPENDED AMENDED item#23a,27,28a-f,perME,g856,6/14/06 TT Box 68760, IF FEMALE 23d Date of delivery 23b Was decedent pregnant in the 3 Ectopic pregnancy Dav Live birth Fetal death Pregnant at time of death 5 1 Yes 2 No 9 V Unknown Unknown Ph 23e. Did tobacco use contribute to the cause of death? O Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 ✔ Unknown م Completed Division of Vital Records, 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 V Yes 26.Place of Death (Check only one) 25. Was case referred to medica Be Other₄ examiner? DOA Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 1 V Yes 2 No 28c. Injury at Work' 28d Describe how injury occurred 27. Manner of Death 28b. Time of Injury After 28a. Date of Injury (Month, Day, Year) Certification: 1 Natural Yes 2 X No 5 Pending Fnd 5/23/2006 To the Funeral Director: Fnd 4:15 pm 2 Accident Investigation 28f. Location (Street and Number of Rural Route Number, City or Town, State) 4904 Goodnow Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be (Specify) Found in residence determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License numbe 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E May 24, 2006 completed cause of death (Item 23a) 30 Name and address of person who 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Voar Month **Physician** 20 2006 5:25 p. Barbara Harris May /Medical 4c. County of Death 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 8044 Gough Street Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🖫 F Yrs 71 217-30-3356 Director Apr. 29, 1935 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c City Town or Location 10a. State 10b. County r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🔯 No Maryland Baltimore Baltimore Direct 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21224 United States 8044 Gough Street death 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours after dail Hygiene.

Other than "natural", or item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygier Impurtant: If item 27 Is marked other it any hjury or other traumatic event, tha once. 10 years Telephone Operator Telephone 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden, Surname) Be Herman E. Edwards, Sr. Jeannette M. Shifflett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 32 Derwood Court Hope Harris Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv. Corp. 5/24/2006 Towson, Maryland 22. Name and Address of Facility 21. Signatur of Euneral Service Licensee Duda-Ruck Funeral Home of Dr. 7922 Wise Avenue Dundalk, I 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Approximate Interval Between Onset and Death Immediate Cause (Final muti infact Dementia **Physician** 3 years disease or condition resulting in death) /Medical Examiner Pseudo xan thoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) the t 1 ☐ Yes 2 ☑ No 9 Unknown 9 ☐ Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown been si 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate has b firector, page 2 s To the Hospital or Attending Physician: " within 24 hours after death. To the Funeral Director; After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 55942 106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N. CHARLES ST # 203 BALTIMORE MM PAUL FOSTER, MO. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 6 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINA

			1 - For State Registrar	of Maryland / Dep <i>Ce</i>	artment of Hea		ygiene 006	16607
	Physici /Medic		1. Decedent's Name (First, Middle, Last) CLARENCE	HANI		2. Date of E Month	125/2006	3. Time of Death
	Examin Funeral Director		4a. Facility Name (If not institution, give street and r Luture Care Drum 5. Social Security Number 6. Sex 213 — 38 — 6548 1 M 2 F	7. Age (In yrs. last birthday,		Under 24 Hrs. 8. Date of E (Month, I	4c. County of Death sirth Day, Year) 9. Birth Coun	place (State or Foreign
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or Items 23a or 28a-f show yent, ira Medical Examinar man be notified a	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD	10c. City, Town or L Baltimon		3(3 / / /	10d. Inside City Limits 11 Yes 2 No
			10e. Street and Number 22 South Athol Ave. 11. Marital Status 1 Never Married 2 Married 1 Yes If Yes, Year or (Specify only highest grade complete	Forces? s 2 No unk Give Dates:	If Yes, specify Cuban, N 1 □ Yes 2 ☒ No S edent's Usual Occupation e kind of work done durin DO NOT use retired) canence	nic Origin? (Specify Yes or Nexican, Puerto Rican, etc.) specify: ng most of working Mother's Name (First, Midd	Black, White, Specify: Wh: 16b. Kind of Business/In	unk can Indian, etc. ite idustry
			19a. Informant's Name/Relationship (Type, Print) Future Care Irving ton 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Is ther (Specify) in state 21. Signature Funeral Sprice Licensee 22. Name and Address of Facility					
of Vital Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed If a close and If a close an	To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last State Anatomy Board 655 W. Baltimore Street State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Approximate Interval Between Onset and Death Due to (or as a consequence of):					
			23b. Was decedent pregnant	egnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably					
			25. Was case referred to medical examiner? 1 Yes 20 No. 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Ultraing Home 5 Residence 6 Other Specific 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Ultraing Home 5 Residence 6 Other Specific 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Ultraing Home 5 Residence 6 Other Specific 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Ultraing Home 5 Residence 6 Other Specific 1 Ultraing Home 1					2 100
		Certification:	2 Accident investigation 3 Suicide 6 Could not be	9 One Diseased Injury At home from attack feeting 295 Location (Street and Number or Dural Double Number				
	To the Hospital within 24 hours a To the Funeral Completely filled	edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	To the within To the Comp	Me	29b. Signature and title of certifier	MD.	29c. License nu	1405	29d. Date signed (<i>Month</i> , 5/19/o 6	Day, Year)
	_		30. Name and address of person who completed c	ause of death (Item 23a) Type 8 2 / - Registrar's Signature	Extens	t Baltim	reMD2	120)
	Sta Regist		MAY 2, 5 2006	Duran H App	all?			

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** may 2006 5 o wise /Medical 4a. Facility Name (It not institution, give street and number)

Good Samaritan Nursing (en ter 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Days Hours 79 Director AR Usual Residence of Decedent 10c. City. Town or Location 10d, Inside City Limits 10a State 10b. County a Hygiene.

Joher than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show svent, the Mcdinal Examiner must be notified at 1X Yes 2 No MD NA Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 U.S.A. 1804 Heathfield Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: Black ۵ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Care Worker State of Maryland 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be is marked Jennie V. Ware Alfred York 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Heelth an Item 27 Joseph Hamilton-Husband
20a. Method of Disposition 1804 Heathfield Road, Baltimore, Md 21239 of Disposition (Name of Date Date 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 5/30/06 Baltimore, Md Cedar Hill 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) metastases to a Pancreatic Cancer **Physician** month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. this certificate has been signed I al director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Winknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Diabetes mellitus 1 Yes 2 No Air...
ar death...
irector: After this ceru...
the funeral director, pr 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Dire 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29b. Signature and title of certifier 29c. License number may 24, 2006 D46504 30. Mame and address of person who completed cause of death (Item 23a) (Type, Print) Good Samaritan Hospital, Baltimore, m D 21286 Nancy Friedley, MD:

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For State Registrar	State	ot Mar	yland / Depa <i>Cei</i>	artment of H tificate of L		•	giene: Reg. No.	2006	16609
			1. Decedent's Name (First, Mide	die, Last)			-		2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		David Lee Hus	sk, Sr.					May 24,	200	6	11:10 P ^M
	Examin		4a. Facility Name (If not instituti	on, give street and r	umber)		4b. City, Town, or	Location of Death			County of Death	
			Stella Maris		1		Timonium If Under 1 Year	If Under 24 Hrs.	Lo. D (Dia		ltimore	
	Funeral		5. Social Security Number	6. Sex 1 (X M 2 ☐ F	7. Age ((In yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da)	y, Year)		nplace (State or Foreign untry)
	Director		212-48-1082 Usual Residence of Decedent			58 Trs.			July 2,	194	/ west	Virginia
	death with the Maryland ima 23a or 28a-f ahow		10a. State 10b. Coun	ty	1	10c. City, Town or Lo	cation					10d. Inside City Limits
	8a-1	Director	Maryland Harfo	ord		Abingdon						1 ☐ Yes 🏂 No
	or 2	Dire	10e. Street and Number				10f. Zip Code			-	en of What Co	intry?
	a 23a	srai	1102 East Vil	cing Court		vor in U.S. 12.1	21009	enanic Origin? (Sr		USA	4. Race - Amer	ican Indian
	item item	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Ma	Armed	Forces? S 2 StNo		Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		Black, White	
936	urs af	by F	3 ☐ Widowed 4 ☐ Divorce	If Yes	Give		1 ☐ Yes 2 ☑ No	Specify:			Specify: Wh	ite
ŏ	2 ho	ted	15. Decede	ent's Education	a()	16a. Dece	dent's Usual Occupa	ation	rina	16b. Kin	of Business/lercial	ndustry
21	thin 7	Completed	Elementary/Secondary (0-12)	T	(1-4or 5+)	life.	DO NOT use retired)				and Painter
Maryland 21215-0036	led w lygier her th	S	12 17. Father's Name (First, Middle	- (oot)		Painte	er	18. Mother's Nam				TOTAL
and	ntal H ed ot	Be	Lee R. Husk	e, Lasi)				Arrietta		Blos	,	
7	hould d Me mark matic	<u>C</u>	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailir	ng Address (Street a					ip Code)
<u>⊠</u>	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heelth and Mental Hygiene 1 f Heelth and Mental Hygiene 1 feet at 1 s marked other than "natural", or itama 23a or 28a-1 ahow then traumatic avant, the Marical Exemples must be multiled at		Ellen M. Husk				East Vik					
ē,	s 1 ar f Hee item oth		20a. Method of Disposition			20b. Place of Dispo	sition (Name of natory or other place	a)	Date	20c. Loc	ation - City or	Town, State
Ë	Page lent o nt: If ry or		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other		m State	Hilltop S			- 06	Tows	on, Mar	yland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after dea Depertment of Heelih and Mental Hygiene. Important: if liem 27 is marked other than "natural", or itama any injury or other traumatic avant, the Marical Examinar can any injury or other traumatic avant, the Marical Examinar can app.e.		21. Signature Funeral Service	ce Licensee	1	Mi	Name and Address Full	nerativ Hon	ne, P.A.			
<u>m</u>	80558		- Crances 0	1 angi	4	13	317 Cokest	oury Road	l, Abing		Maryla	nd 21009
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that st only one cause of	t caused the each line	he death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. PAN	CREAT	TIC CANCER						
	/Medical Examiner		1030ining in County	Due	o (or as a	consequence of):						
	ğ.	e	Sequentially list conditions,	b. Due	o (or as a	consequence of						
V	uted	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1								
ó	an an	Exa	resulting in death) Last	Due	o (or as a	consequence of):						
68760,	ificate be executed g physician and as the burial-transit	edical		d.								
_	- O 6		IF FEMALE:			7 - C-12 - C-18						
Box	death certif e attending id for use a	lan/	23b. Was decedent pregnant in the past 12 months?		e birth 2	Fetal death 3	Dectopic pregnancy Other (specify)			2:	3d. Date of deli Month	very Day Year
	o o	by Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Un		ine or dealir 5L	Other (specify)					
P.0	requires thet the een signed by th hould be detache	y Ph	Part II. Other significant condi	itions contributing to	death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco us	se contribute to	the cause of death?
rds	quires n sign uld be	q p							101	es 2[No 3∏Pro	obabiy 4 ∑ Unknown
Ö	> 40	Completed							24a. Was		24b. Were au	topsy findings available
Re	0 5 0	mo							autop perfo 1 Tyes	rmed?	death?	topsy findings available ompletion of cause of
ital	sician: Th certificate rector, pag	Bec	25. Was case referred to medi- examiner?	cal				26. Place of Dea				
<u>></u>	hysic this ce al dire	2	1 ☐ Yes 2 No			2 ER/Outpatier		4 C Italiang In				HOSPICE
ū	ng F fter ner	iuo!	27. Manner of Death 1 Natural 5 Pen	ug	te of Injury onth, Day	Year) 28b. Time o	Work		28d. Describe h	now injury	occurred	
Sic		cat	3 ☐ Suicide 6 ☐ Cou		on of Injur	y - At home, farm, st		Yes 2 □No	28f Location /	Street and	Number or Pu	ral Route Number.
Division of Vital Records,	ii or Attend after death i Diractor: d in by the i	Certification:	4 Homicide dete	mined 200. Fig	ilding, etc.	(Specify)	eer, ractory, onlos		City or Tox			ALTIGUE TAINBOI,
	Hospital	al C				my knowledge, deat						
	To the Hospital or Atti within 24 hours after de To the Funeral Directo completaly filled in by ti	edical	(Check only 2 Medic		basis of e	examination and/or in ed.	vestigation, in my or	pinion, death occur	red at the time,	date and	place, and due	to the cause(s)
	To the composite of the	Σ	29b. Signature and title of certi	fier			29c. License	number		29d. Date	signed (Month	
	Λ.		1 / ~				1243	725		Ć	5/25/	06
	ĺ		30. Name and address of person									
	Sta	to	DR. TARIQ MA 31. Date filed (Month, Day, Yei	HMOOD 23	. Registrar	LANEY VAL. 's Signature	LEY RD.	TIMONIUM	MD 210	193		
	Regist		MAY	2 6 2006	No.	's Signature	Gosse					

MAY 24, 2006 11:15 p.m.

DAVID HUSK

			For State Registrar	State of Many	rland / Dep <i>Ce</i>	artment of rtificate o	Health a f Death	nd Mental Hy	giené [] [Reg. No.	96	16610
· · · ·		0.9	1. Decedent's Name (First, Middle, Las	")				2. Date of De. Month	ath Day	Year	3. Time of Death
	Physicia /Medic	_	G. Alan	Hellaw	ell , Jr.			May 22,		Toal	2:10 A ^M
è	Examin	_	4a. Facility Name (If not institution, give				, or Location of	Death	4c. County	of Death	
		<u> </u>	338 Hart Road			Gaithe			Montgo	omery	
ik A	Funeral Director		5. Social Security Number 6. Se 137–32–6586	XIM 2 TF	n yrs. last birthday 54 Yrs.	Months Day	ar If Under 2	Min. (Month, Da	8, 1941	Coun	ace (State or Foreign try) York
	pu 💌	-	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10	Od. Inside City Limits
	anyla eho	ō									1 XYes 2 No
	28a-f	Director	Maryland Montgome 10e. Street and Number	ery	Gaithers	10f. Zip Code			10g. Citizen of V	Vhat Coun	trv?
	with a or					20878					
	eeth	era	338 Hart Road	12. Was Decedent Eve	r in U.S. 13		f Hispanic Orig	in? (Specify Yes or No Puerto Rican, etc.)	United 14. Race	o Americ	
30	is 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene, item 27 is marked other then "natural", or iteme 23s or 28s-1 show other traumatic event, the Micologia Examination and the notified at	by Funeral	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 \text{\text{\text{X}} Yes 2 \subseteq No} \text{If Yes, Give} \text{Year or Dates: \text{\text{V}}		If Yes, specify Control of the State of the		Puerto Rican, etc.)	Spec ify	k, White, e	ite
Maryland 21215-0036	hour	edt	15. Decedent's Ed		ietnam 16a. Dec	edent's Usual Occ	cupation		16b. Kind of Bu		
Ď	in 72 n" n	Completed	(Specify only highest grad	de completed)	(Giv	e kind of work dor DO NOT use ret Ctor of	e during most	of working			,
7	in the	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Direc	Evalu	riannin ation	g and	Departm	ent (of Commerce
Ö	Hyg other	Be C	17. Father's Name (First, Middle, Last)				18. Mother	's Name (First, Middle,			
<u>a</u>	lid be lenta ked ked	To B	George A. Hella	awe11			Ali	ce Rasch			
3	shou nd M mar		19a. Informant's Name/Relationship (7		19b. Mai	ing Address (Stre	et and Number	or Rural Route Number	er, City or Town,	State, Zip	Code)
Σ	alth a		Ellen L. Hellawel	L1/Wife	338	Hart Ro	ad, Gai	thersburg,	Marylar	d 20	0878
ē.	item		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Name of ematory or other p	nlace)	Date 2.5	20c. Location -	City or To	wn, State
Ë	Pages nent of int: If it		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Montgóme Cremato	ry	1 1	May 25, 2006	Bethesd	a. Ma	arvland
Baltimore,	permit. Pages Department of I Important: If its any injury or o	1	21. Signal Truneral Service Lice	8	Gremator	2. Name and Add	dress of Facility	Robert A.	Pumphre	y Fur	neral Home/ Avenue
ă	Ded in a		1 Stral	e mi	м00803	Rockvill Rockvill	e, Inc. e. Marv	1and 2085	Montgon 0-2805	ery A	Avenue
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.		nter the mode of d			rrest,		Approximate Interval Between Onset and Death
• %	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):						
			Sequentially list conditions,	b. Due to for as a c	onsy lience of)-						
1	pe lisit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to for as a c	orise dualica oi)						
/_	ate be executed hysician and the burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):					-	
8760	be e sician buria	a E		. =							
687	ate th	dical		d.							
.O. Box (that the death certific led by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnal □ Other (specify)			23d. Dat Moi	e of delive	ry Day Year
<u> </u>	hat thid by	Ph	Part II. Dther significant conditions co	ontributing to death but n	ot resulting in the	underlying cause	given in Part I.	23e. Did t	obacco use conti	bute to th	e cause of death?
ords,	w requires t been signe should be	ted by					3				ably 4 □Unknown
Reco	e la has	Completed							ormed?	Vere autoportor to confeath?	osy findings available inpletion of cause of
ta		0	25. Was case referred to medical				26. Place	of Death (Check only of			20140
>	Physician: this certificanal director, is	To B	examiner? 1 ☐ Yes 2 🎇 No	Hospital:	2 ER/Outpatio	ent 3 DOA	Ath an	sing Home 5X Resi		er (Specify	·)
on of	Attending Physician: r death. ector: After this certificator. By the funeral director.		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Y	ear) 28b. Time Injury	V		28d. Describe	how injury occurr		,
Division of Vital Records,	in The	Certification:	3 Suicide 6 Could not be determined		- At home, farm, s Specify)	treet, factory, office	C O	28f. Location (- City or Tou	Street and Numb wn, State)	er or Rura	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I	edical C		ysician: To the best of n niner: On the basis of ex and manner stated	amination and/or						
	To the within To the comple	Me	29b. Signature and title of certifier	911	Ma		ense number		29d. Date signed	1 (Month, L	Dey, Year)
,	18		Nege	1) Sur			29353		May 22,	2006	
	25		30. Name and address of p on who				#025	Ol	- 1/- 1		20015
in.	U C		George Graves, M	.D. 5530 W		Avenue,	#925,	Chevy Chas	e, Maryl	and	20815
	Sta Regist			906 See		barte					

			For State Registrar	State of Ma	aryland		artment of H			Reg. N	2001	5 16611
	Physici		1. Decedent's Name (First, Middle, Las	IPSARC)					Date of Death Month	9 200	
	/Medic Examin		4a. Fecility Name (If not institution, give				4b. City, Town, o	or Location o	of Death		c. County of De	
	LAGITIT	ات خ	GOOD SAMARIT	TAN HOS	PITA	4	BALT	1100	25	8	ALTIM	ore city
100	Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. las		If Under 1 Year Months Days	If Under 2	24 Hrs. 8. [Min.	Date of Birth	g. B	irthplace (State or Foreign Country)
	Director		220-20-0084	□M 2XF	78	Yrs.	Worth's Days	110013	Ju	Date of Birth Month, Day, Yea LNC 10,	1927 Me	aryland
	pu 🔉		Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Lo	cation					10d. Inside City Limits
	anyla show	'n	Maryland N/A		loo. Ony,		ultimore					1 ☐ Yes 2 ☑ No
	the M	ect	10e, Street and Number			ມເ	10f. Zip Code			10a (Citizen of What	Country?
	a or	급	3423 E. Northern	Parbwau			101. Zip 0000	21	206		u.s.A	•
	ns 23	Funeral Director	11. Marital Slatus	12. Was Decedent	Ever in U.S.	. 13.1	Was Decedent of I f Yes, specify Cub			Yes or No-		nerican Indian,
10	r Iten	핊	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑	No	1				ın, etc.)	Black, Wi	
8	al', o	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		į	1□Yes 2⊠ No	Specify:			Specify: WV	rite
21215-0036	within 72 hours after death with the Maryland liene. r then "natural", or Items 23a or 28s-f show the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra-			(Give	lent's Usual Occup	during most	t of working	16b.	Kind of Busines	ss/Industry
2	ithin New Mass	Jqr.	Elementary/Secondary (0-12)	College (1-4or	5+)		00 NOT use retire Imemaker	d)			Own t	lama
			12 17. Father's Name (First, Middle, Last)			110	menuket	18 Molhe	ar's Name (Fi	rst, Middle, Maid		ione
Maryland	d fall b	Be	Joseph Tenagli	а					izabet		rowski	
Z	should ind Men marke	2	19a, Informant's Name/Relationship (7			19b. Mailir	ng Address (Street					. Zip Code)
Z	nd 2 sho Ith and 27 is m r traum			daughter)			Northco					95014
ē,	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		20a. Method of Disposition		20b. Pla		sition (Name of natory or other pla		Date		Location - City	or Town, State
e E			1 Donation 5 Other (Specify		Gara	dens o	A Faith	Cem.	5/24/2	006 Bal	timore,	Maryland
Baltimore,	世世世世上		21. Signature of Funeral Service Licen	S00		22	. Name and Addre	ss of Facilit	y Schim	unek Fur	ieral Ho	imes
m	Depz impo		Mal			9	705 Belo	iir Rd	., Bal	timore,	MD 2123	36
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused one cause on each li	d lhe death. ne.	Do not ent	er the mode of dy	ng, such as	cardiac or res	spiratory arrest,		Approximate Interval Between
H	Physician		Immediate Cause (Final disease or condition	ACUTE	MY	Oc 48	DIAL	INF	FARC	TION		Onset and Death
455	/Medical		resulting in death)	Due to (or as	a conseque	ence of):						
	Examiner	_	Sequentially list conditions,	b								
7	pe tis	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as	a conseque	ince on.						
)	death certificate be executed e attending physician and id for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):						
68760,	be ear	calE										
687	ficate p phys is the			0.								
Box	leath certificat attending phy I for use as th	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			ie . ik				23d. Date of c	delivery
ň	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 No	1 Live birth 4 Pregnant a			Ectopic pregnand Other (specify) _	y			Month	Day Year
P.0		Physician/Med	9 Unknown	9Ll Unknown								
	as tha	by F	Part II. Other significant conditions of	ontributing to death b	ul not result	ting in the u	nderlying cause gr	ven in Part I.		23e. Did tobacc	use contribute	to the cause of death?
Records,	w require been si									1 🗆 Yes	2 No 3	Probably 4 Niknown
GC	elawr hasbe je 2 sh	ple								24a. Was an autopsy	24b. Were prior t	autopsy findings available o completion of cause of ?
<u> </u>		Completed								performed?	death lo 1 ☐ Y	? es 2□No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			10		of Death (Cl	heck only one)		
of	두 두 =	ို	1 XYes 2 No	1 🔲 Inpati		Outpatier	IL 3 DOA			5 Residence		pecify)
n C	ding F th.	lo Lo	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	Wo	nyat nrk?]Yes 2. □l		Describe how in	jury occurred	
isic	death death stor: / the	cat	2 Accident investigation 3 Suicide 6 Could not be		ury - At hon	ne farm str	eet, factory, office			Location (Street	and Number or	Rural Route Number,
Division	after Direction by	Certification:	4 Homicide determined		c. (Specify)		cot, ractory, critico			City or Town, Sta	ite)	, 10101 1 1010 1 10110 0 1
	spita nours neral		29a, Certifier 1X Certifying Ph	ysician: To the best	of my know	rledge, deat	n occurred at the t	ime, date an	nd place, and	due to the cause	(s) and manner	as stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Exam	niner: On the basis of and manner st	f examination	on and/or in	vestigation, in my	opinion, dea	ith occurred a	t the lime, date a	nd place, and d	ue to the cause(s)
	To the within To the comp	×	29b. Signature and title of certifier	X	1		29c. Licen	se number			ate signed (Mo	
	,		1 Yer	if Xec	1/1	MD	1	5843	53	M	Ay 19 +	2006
-	(5)		30. Name and a ress of per on wh	completed cause of	h (Item :	23a) (Type,						_
	1		KERITH JO	१६९५ 5		-oct	RAVEN	BLVD	BAL	TIMORE	JUN 1	21239
	Sta Regist	ate	31. Date filed (Moeth, Pay, Xear) 21	32 Regist	ars Signati	A A	DASC D					
DI	HMH 17 Rev 1/2	16		A STATE OF THE PARTY OF THE PAR	الأجمه المساة	and the same					Ů.	

Amend item#18,19a, perInf C856.6/15/06 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Henry 05 18:37 /Medical 06 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**⋤**M 2□ F Yrs. Director 01 06 35 248-56-1078 Usual Residence of Decedent South Carolina 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits •how is 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Item 27 ie marked other then "neturel", or items 23e or 28e-f ehov other treumstic event, Ite Madical Exart it entitles notified at Yes 2 No Directo Washington 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 2855 Bladensburg Rd. N.E. #223 20018 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. □Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th. Food Services Ledo Pizza 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lionel HArtwell Lerenisher Isaac ٩ Pages 1 end 2 should nent of Health and Mer 19a. Interment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thilip Frazier/Cousin 1758 Lyman Pl. N.E. Wash. D.C. 20002 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition permit. Pages
Department of I
Important: If ite
any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cem. 05 - 23 - 06Brentwood, MD. 22. Name and Address of Facility MArshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, D.C. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed burial-transit Box 68760,小 Due to (or as a consequence of): Physician/Medical as the IF FEMALE. **08**0 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e ☐Yes 2 DNo o<u>i</u> 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown certificate has been s rector, page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe home 1 ☐ Yes Division of Vital Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 2. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Tyes 2 No 1 Dipatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After 1 Matural 5 Pending 2 No 1 Yes death. 2 Accident investigation filled in by the 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the th 29b. Signature and title of the life 29c. License number 47867

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

DHMH 17 Rev 1/2001

Coeste

701

2. Registrar's Signature

RANDOLPH Rd. RockvillE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

6 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** Johnson Anastasia Theresa 2006 25. 11:35 A M May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore 4104 Westmeath Road Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 12, 1905 9. Birthplace (State or Foreign Country)
Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months 1 □ M 2 1 F 101 212-74-1511 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a State 10b. County permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "netural", or Itams 23a or 28a-f show any injury or other traumatic event, Ira Madical Examiner must be mailified at once. 1 ☐Yes 2 No Baltimore Completed by Funeral Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 21236 4104 Westmeath Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Stella Opanowic Ignatius Fisher 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4104 Westmeath Road, Baltimore, MD 21236 Constance Johnson (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/30/2006 Fullerton, Maryland St. Joseph Ch. Cem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Road, Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ATHEROSCLEROTIC Immediate Cause (Final HEART DISEASE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a consequer or of Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) he 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ EMENTIA 1 Yes 2 Xo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 22 No 2 No 1 Yes 1 Yes Hospital or Attanding Physician: 24 hours after death. Funaral Diractor: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 2 No 2 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 4 000 30. Nam a address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar PARSHALL

31. Date filed (Month

3 Registrar's Signature

FRANKLIN SQUARE DR.

BALTIMORE, MD

Jankowak, Antoinette.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mai Antoinette Estella Jankowiak 2006 10:00 Am /Medical 4b. City, Town, or Location of Cath 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) Examiner BALTIMORG HAMILTON GENESIS CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign
Country) **Funeral** Months Days 1□M 2\ F Yrs. July 14.1921 214-12-9554 Maryland Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Department of Haalth and Mantal Hygians. Department of Haalth and Mantal Hygians. Instruction to theme 23a or 28a-f ehow important: If them 27 is marked other than "natural", or items 23a or 28a-f ehow any Injury or other traumatic event, its Medical Examine must be notified at 1X Yes 2 No Directo Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3410 Erdman Avenue 21213 u. S. A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yas 2 No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 11th Grade Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Luigi Masucci Maria Gabriella Villani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Jankowiak (Husband) 3410 Erdman Avenue, Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bauview Crematoru 05/26/2006 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Marykand 21213 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical a METASTATIC CANCER IN Examiner Due to (or es a consequence of): Examine CATUC attending physician and for usa as the bunal-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) resulting in deeth) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 24b. Were eutopsy findings avaitable prior to completion of cause of death? 24a. Was an autopsy Completed 2 No 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28c. Injury at Work? 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of ** Hospital or Ats.
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** by the fur 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ATTENDING PHYSKIM 00062239 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) HAMILTON BALTIMORE CONTER

State

Registrar

31. Date filed (Month, Day, Year)

32. Paistrer's Signeture

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2006 2:10 P. 21, Peggy Ann Jarels May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Baltimore 2903 Georgia Avenue If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (Lg xrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 21 F 231-52-2002 Director 08/05/1935 Pembrook VA Usual Residence of Decedent 10d. Inside City_Limits 10a. State 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD 2903 Georgia Ave. Baltimore MD <u>Baltimore</u> 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 2903 Georgia Ave. 21227 USA death Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural; or iten ury or other traumatic avent, its Mental at 1 ☐ Yes A No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 th Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clarence Morris Dora Lucas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2903 Georgia Ave Baltimore Maryland 21227 Marshall Jarels Husband 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Loudon Park Cemetery 05/25/06 1 57 Burial 2 Commation 3 Removal from State 4 Donation (Donation) ment of Important: If it any injury or o <u>once</u>. Baltimore MD 21229 permit. 21. signature of property service Lice see 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave Baltimore Maryland 21229 part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ATHERO SCLEROTIC nediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical the attending p as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. ģ signed t 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed (PAS 64a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
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State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MSNEEM

MAY 2 6 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



7220

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 16616

Usual Residence of Oecedent Top Street and Number Top Top Street and Number	Limits No
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29c. License number 29d. Date signed (Month, Day, Year, O.C.M.E. May 26, 2006	
30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31 Oate filed (Month, Day Year) 32. Registrar's Signature Registrar	

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	ding Ph h. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pendin	28a. Date of Inj (Month, D	ury 28b. Time ay Year) Injury		Bc. Injury Work			28d. Describe I	now injury	occurred		
sio	Attending or death.	cati	2 Accident Investig	not be	aius. At hama farm	M		Yes 2□		28f. Location (5	Stroot and	Number of C	Pural Paula Mu	
Division	P Site	Certification:	4 ☐ Homicide determ	ined 288. Place of It	njury - At home, farm, s etc. <i>(Specify)</i>	treet, ractory,	, once			City or Tov		VUIIDUI OI A	urai noute ivui	noer,
_	To the Hospital within 24 hours a To the Funeral completely filled			g Physician: To the bes										- 555 a-400
	To the Hospital within 24 hours To the Funeral completely filed	Medical	(Check only 2 Medical one)	Examiner: On the basis and manner s		nvestigation,	in my op	oinion, dea	ath occurre	ed at the time,	date and p	lace, and du	e to the cause	(s)
	To the within To the Comp	Σ	29b. Signature and title of certifie	r		29c.		number			29d. Date	signed (Mon	th, Day, Year)	
			> syllu	_m.D.			DE	744	13		05	119/	1006	
1	541		30. ame and address of person	who completed cause of	death (Item 23a) (Ty	, Print)	R	St.	B	altin	neto.	mo	212	25
	- St	ate	31. Date filed (Month, Day, Year)	0.0	trar's Signature	1 4			-	1				
	Regist		MAY 2	6 2006	was St. 1	GORAGE								

VOID

V. Jerry 5/30/06

certificate no.: 06-16618

		•	1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certificate of Death
2-	Physici		1. Decedent's Name (First, Middle, Last) MARY P. KLIMASZEWSKI 2. Date of Death Month May 24, 2006 11:28 PM
1	/Medio Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
4	36	46	Baltimore-Washington Medical Center Glen Burnie Anne Arundel
	Funeral Director		S. Social Security Number 204-01-0955 Usual Residence of Decedent 6. Sex 1 M 20 F 7. Age (In yrs. last birthday) 89 Yrs. 1 Months Days Hours Min. 1 Days Hours Min. 1 Days Hours Min. 1 M 20 F Pennsylvania
	/land		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Man,	tor	Maryland N/A Baltimore 1⊠Yes 2□No
	th with the 23a or 28	al Dire	10e. Street and Number 4217 Fifth Street 10f. Zip Code 21225 10g. Citizen of What Country? USA
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "natural", or items 23s or 28s-1 show other traumatic event, If a Medical Examinational Le notified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Microroad 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Microroad 12. Was Decedent Ever in U.S. Armed Forces? 1 No Specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No Specify: White
5-0	72 h	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) 16b. Kind of Business/Industry
121	2 should be filed within 7 n and Mental Hygiene. 7 is marked other than "r raumatic event, in a Medical manage.	mp	Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) Test Repair Westinghouse Corp.
d 2	Hygie Hygie other	Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Maryland	ld be ental ked c	To Be	Clement Polyniak Barbara Krupa
ary	shou ind M mar	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	1 and 2 Health a em 27 le		Barbara M/ Cassel (Daughter) 208 Hammarlee Rd., Glen Burnie, Md. 21061
Baltimore,	permit. Pages 1 an Depertment of Heal Important: if item 2 any injury or other once.		20a. Method of Disposition 1 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) Glen Haven Mem. Pk. 5/27/2006 20c. Location - City or Town, State 5/27/2006 Glen Burnie, Maryland
Bait	permit. Page Depertment o Important: If any Injury or once.		21. Signature of Enhance Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856
	Physician /Medical Examiner	ler	23a. Part1. Errier the disease, or complications that caused the death. Do not errier the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Pranty: Sequentiatly list conditions
68760,	ificate be executed g physicien and as the burial-transit	edical Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.
О. Вох	deeth cert e attending d for use	Completed by Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1
ds, P	w requires that the sbeen signed by the should be detache	d by P	Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Ö	> 0 0	lete	1+r PS-2 TEAS TEAU) 24a. Was an 24b. Were autopsy findings available
Re	0 - 0	ome	autopsy prior to completion of cause of performed?
ita	ician: Th certificate rector, pag	0	25. Was case referred to medical 26. Place of Death / Check only one)
<u>_</u>	S D	To B	examiner? 1 Yes 2 No
Division of Vital Records,	and the same	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of frijury 28b. Time of Irijury 28b. Time of Irijury 4 Work? 1 Yes 2 No
Divi	tal or Att is after d al Diract ed in by t	Certifle	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To t To t	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/24/2006
	5		Jose, M.D. D19991 5/29/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Davis Ress, W.D. Susger 4/2 200 //USPERGE DRAZ CIEN BURNER, MARYLY
	Sta		31. Date fifed (Month, Day, Year) 32. Registrar's Signature
Di	Regist	al	MAY 2 6 2006 January St. Special

State of Maryland / Department of Health and Mental Hygien® Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 11:50 AM M May 24, 2006 Lerov J. Knight /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Brightwood Center Baltimore Lutherville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/21/1924 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours 1 № M 2 🗆 F 82 Yrs ÞΑ 193-12-4681 Director Usual Residence of Decedent with the Maryland 10d Inside City Limits 10c. City. Town or Location 10b. County 10a, State rthan "natural", or items 23s or 28s-f show its Medical Examiner must be notified at 1 ☐ Yes 2 No MD Baltimore Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 United States 916 Starbit Road death 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1942-1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. White þ 3 M Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Federal Government Il Hygiene. Colfege (1-4or 5+) Elementary/Secondary (0-12) Procurement Manager 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17, Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked oth any injury or other traumatic event once. Amelia Rabiega Krzyzanowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Emalee Smith/Daughter 749 Juli Drive New Freedom, PA 17349 20b. Place of Disposition (Name of cemetery, crematory or other place) May 27 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Lutherville Timonium, Dulaney Valley Memorial 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation and Funeral Alternatives CB800M Hubble 8717 Green Pastures Drive Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final 5e ps15 day **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DIABETES MELLITUS month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit THRIVE 70 FAILURE resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year Month Dav in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan ate has t page 2 s autopsy performed 1 🗌 Yes 2 🗌 No certificate 1□ Yes 2☑ No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 1 Inpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? eral Director: After th 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 TTYes 2 No death. investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie MAY 2500 200 6 D0053150 MD MP 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Juste 10 9650 scrifte Road 21045 hakunmak 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State MAY 2 6 2006 Registrar

			For State Registrar	State o	f Maryla	and / Depa	artment rtificate					giene Reg. No. ()	06	16621
	Physici	an	1. Decedent's Name (First, Middle, La								2. Date of De Month	Day	Year	3. Time of Death 8:25 P.M
	/Medic	al	Dorothy L. Ker 4a. Facility Name (If not institution, gi		mber)		4b. City. 7	Town, or	Location	of Death	May 23	•	ty of Death	0:25 P.'''
	Examin	er	Gilchrist Hospid					owso					imore	
ę	Funeral Director		220-09-4958	Sex 1 □ M 2 ☑ F	7. Age (In y	rs. last birthday) 1 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir June 2	* 1921	9. Birthp Cour Mary	place (State or Foreign Land
	and		Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	ocation						1	Od. Inside City Limits
	Maryl February	tor	Maryland N/A	7	I	Baltimor	e							Yes 2□No
	n with the 3a or 28s	al Director	10e. Street and Number 1105 Falls Hill	Drive			10f. Zip	Code 21	211			10g. Citizen o	What Cour	ntry?
9	EXITIMOTE, IMATY INDICATIONS permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any righty or other traumatic event, it is Marked Examination and once. once.	y Funerai	11. Marital Status 1 Never Married	12. Was Deci Armed Fo 1 Tes If Yes, Gir	orces? 2 ½ No ve	n U.S. 13.	Was Deced If Yes, spec 1 ☐ Yes 2				ecify Yes or No Rican, etc.)	- 14. Ra Bi Spec	ace - Amendack, White,	
Š	tural,	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's 8	Year or D	ates:	16a. Dece	dent's Usua	i Occupa	ation			16b. Kind of	Business/In	dustry
4	6. "na "na Marie	Be Completed by	(Specify only highest gi Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)		dent's Usua kind of wor DO NOT us		turing mos)	st of work	ing		wn Ho	vmQ
Š	iled will tygien that the nt. If a	Con	10 17. Father's Name (First, Middle, Las	f)		I	Iomema	ker	18. Moth	er's Name	e (First, Middle	<u> </u>		
9	id be fi ental h kad ot ic eval	To Be	Joseph Schuch	.,							erine L			
	Maryliand Z I Z I 3-0030 Id 2 should be filed within 72 hours aft th and Mantal Hygiene. Z is marked other then "natural", or traumatic event, it e Mydical Exami	n 7	19a. Informant's Name/Relationship Melvin A. Kence		ısband						al Route Numb Balti			nd 21211
9	or Heal	1 8	20a. Method of Disposition 12 □ Cremation 3	Removal from		b. Place of Disp cemetery, cre	osition (Nam matory or ot	ne of ther plac	Θ)		Date	20c. Location	-	
	Baltimore, permit. Pages 1 a Department of Hec Important: If Itam any injury or otha		`4 □ Donation 5 □ Other (Spec	ify)	D	ulaney \					2006	Cockeys	sville	e, Maryland
2	Danit Permit Depar Impor any in		21. Signalure of Funeral Service Lic	Alexs	1)	B ₁		Hens IIIs	ss-Se Road	itz , Ba	Funeral ltimore		Inc. Land	21211
			23a. Part1. Enter the disease, or co shock, or heart failure. List onl	mplications that of	caused the c each line.	leath. Do not en	ter the mode	e of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	aDue to	or as a con	l Far sequence of):	ilu	re			•		-	
8:35pm	Examiner		Sequentially list conditions	b	05401	dirm	dit	Suit	ود	01.1	h.			
3	ig &/A	niner	Sequentially list conditions, large leading to immediate cause. Enter Underlying Cause (Disease or injury		for as a con	sequence of):	for	An	10 -	M =2 =	1 i c			
	60, 60 be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Ç.		sequence of):		1		(0)	77.50			
90	W 2 0	ical		d									L.	
93/	BOX 68 eath certificat attending phy	cian/Med	IF FEMALE:	23c. If yes, ou	itcome of pre	agnancy						224 [ate of delive	00/
16	. 0 00	Physician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live	birth 2 ☐ I nant at time	etal death 3	□Ectopic pr □ Other (sp						Month	Day Year
	S, F es tha gned be de	b	Part II. Other significant conditions	/\	leath but not					i.				he cause of death?
12	ecord law requir as been si	ompieted	Congestine He	st For	luce	(utri	tion	24a. Was	an 24t	. Were auto	posy findings available
To	I Rec	Comp	Diebetes Mal	1.7 ms		-					auto	ormed?	death?	mpletion of cause of 2□ No
\Diamond :	of VItal F Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth			h (Check only			11-0-05
0)	Of Phys this ral di	n: To	1 Yes 2 No 27. Manner of Death	1	Inpatient of Injury oth, Day Yea	2 ER/Outpatie		Bc. Injun Worl		ursing Ho	ome 5 Resi 28d. Describe	how injury occ		N) MOSPICE
3.	anding F auth. or: After he funera	atio	1 Natural 5 Pending 2 Accident investigat	ion	iii, Day 19a	r) Injury	М		Yes 2	No				
3	Division or Attanding after death. Diractor: Afte	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		e of Injury - A ding, etc. (Sp	At home, farm, s pecify)	treet, factory	, office				'Street and Nur wn, State)	nber or Rura	al Route Number,
Kg.	Division To the Hospital or Attanding within 24 hours after death. To the Funaral Director: After completely filled in by the funa	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex											
	To th within To th	Me	29b. Signature and title of certifier). m	Con	eh			e number	19		29d. Date sign	ned (Month,	Day, Year)
	4		30. Name and address of person wh	((Item 23a) (Type	, Print)				W:11.	in 1	M	1 (Danill
	St Regist	ate	31. Date filed (Month, Day, Year) MAY 2 6 20	06 32.	Registrar's S		All s	- d= (207					
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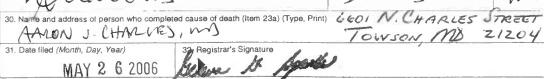
State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 22, 2006 6:35 P M Henrietta Mae Knoph May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. North, Day, Year)

Yrs. Months Days Hours Min. Dec. 20, 1922 Aberdeen Harford 344 Carter Street 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2X F Director 122-18-0508 NEW YORK Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10h. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f ehow other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Directo Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 344 Carter Street 21001 USA Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other them any injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 XNo Specify: þ 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done d. life. DO NOT use retired) during most of working College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilson John M. Angela Snyder ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Knoph/Son 344 Carter Street, Aberdeen, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 5-24-06 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CHRONIC BRONCHIECTASIS disease or condition resulting in death) /Medical CHRONIC ORSTRUCTIVE PULMONARY DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATRIAL FIBRILLATION 1 Yes 2 Ho 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate 2 4 No 1 ☐ Yes 2 ☐ No 1 Yes : After this certification and funeral director. or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 DNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) now Novalions 108096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 125 N. MAIN ST. BEZ AIR, MOZERY ANDREN Nouskowski 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			Please T	ype or Print in B					_	e.
		•	For State Registrer	State of Maryland	•		Health and I f Death		giene	6 16623
Dh	-1-1-		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day Ye	3. Time of Death
	rsicia: ledica		Margaret Mar	9 9				May	24, 2006	9:00 p. м
Exa	amine	r	4a. Facility Name (If not institution, give s		4	_	, or Location of Death	ו	4c. County of [
			Gilchrist Cer 5. Social Security Number 6. Sex		st hirthday)	f Under 1 Yea	WSON ar If Under 24 Hrs.	8. Date of Bir	h o	imore Co. Birthplace (State or Foreign
Fune Direc				M 2X1 81		fonths Day		April 1	7. Year)	Country) Maryland
Ð			Usual Residence of Decedent					p. 11	0,1520	
ırylan	3	_	10a. State 10b. County		Town or Locat					10d. Inside City Limits
he Ma		200	Maryland N/A	Ba	altimor					Yes 2 No
with ti		Funeral Director	10e. Street and Number 6518 Alta Avenue			10f. Zip Code			10g. Citizen of Wha	-
eath y		e .		12. Was Decedent Ever in U.S	13 Was		21206		United St	ates American Indian.
fter d			1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No	1		f Hispanic Origin? (S uban, Mexican, Puert	o Rican, etc.)	Black, V	Vhite, etc.
urs a		2	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 -	Yes 2XIN	lo Specify:		Specify:	White
72 hc		Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Deceden (Give kin	d of work don	ne during most of wor	rking	16b. Kind of Busin	ess/Industry
Han dithin	a Ma	E I	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use reti hier	ired)		Dana C	+000
Hygie ther t	1	2	8 yrs. 17. Father's Name (First, Middle, Last)		Casi	11161	18. Mother's Nan	ne (First, Middle,	Drug S	rone
d be antal	2	0 0	Joseph Anthony	Leonard			Lillia			rrv
at y iditio Z I Z I 3-0030 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. In marked other than "natural; or Itema 23e or 28e-1 show	DE L	-	19a. Informant's Name/Relationship (Ty		19b. Mailing A	Address (Stre	et and Number or Ru			7
Ind 2 elth a 27 la	ar tra		Mrs. Sandra E. Lid	ard /Daughter	6518	Alta	Avenue Ba	altimore	, Marylan	d 21206
es 1 a	r other		20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ R	20b. Pla	nce of Disposition	on (Name of ory or other p	nlace)	Date	20c. Location - City	y or Town, State
Pag ment	o di		'4 □Donation 5 □Other (Specify)	More	eland Me	em. Pa	rk 5/27	7/2006	Baltimor	e, Maryland
DESILITIOTE, INCLYIGITION 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 ta marked other than "natural", or itema 23a or 28a-f ehow	ny in		21. Signature of Funeral Service License	Michael E. Canap	op		dress of Facility		5305 Hart	ford Road
ع مة	8 O	-	Mich C	ing. /.			d J. Ruck,			e, MD 21214 Approximate
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	Do not enter t	ne mode or d	ying, such as cardiad	or respiratory a	Test,	Interval Between Onset and Death
Physic /Medi	_		disease or condition resulting in death)	Breast		21				years
Exami			- 1	Due to (or as a conseque	ence or):					
7		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):					
ecuted and	ransii	amine	Cause (Disease or injury that initiated events	:						
death certificate be executed e attending physicien and		Ĭ	resulting in death) Last	Due to (or as a conseque	ence of):					
ficate be explosed by physicien	e L	Ica		l						
OX O h certific anding p	96 28	Me	IF FEMALE:	3c. If yes, outcome of pregnan	CV					
eath c	0	Physician/medical	23b. Was decedent pregnant in the past 12 months? 1 \(\subsection \text{Yes} \) 2 \(\subsection \text{No} \)	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3□Ec	topic pregnar			23d. Date of Month	Day Year
the the	sched	ysi	1 ☐ Yes 2 LXNo 9 ☐ Unknown	9□ Unknown		,-,-,,				
s that	9 4	oy P	Part II. Other significent conditions cor	tributing to death but not resul	ting in the unde	rlying cause	given in Part I.	23e. Did te	obacco use contribut	te to the cause of death?
v requires	ם פון							1 🗆 1	/es 2. No 3 [Probably 4 Unknown
aw re	s sho	Completed						24a. Was		autopsy findings available to completion of cause of
The The ate ha	page	é						perfo	rmed? deat 2. X No 1 □	h?
VICAL Iclan: Sertifica	ctor,	De	25. Was case referred to medical examiner?					th (Check only o	ne)	
Physic This co	d dire	0	1 ☐ Yes 2 No	lospital: 1 Inpatient 2 E		3LI DOA			dence 6 Other (S	Specify) Hospice
nding F th.	runer:	0	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In W	juryat łork? □Yes 2□No	28d. Describe h	now injury occurred	
Attanding r death, actor: After	eu /	Icar	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hon	ne farm street			28f. Location (5	Street and Number o	r Rural Route Number,
after Dira	<u>c</u>	Certification:	4 Homicide determined	building, etc. (Specify)	,			City or Tov	m, State)	
DIVISION OF VICAL RECORDS, F.O. DOX OOLOD, To the Hospital or Attanding Physician: The law requires that the death certificate be exe within 24 hours after death. To the Funerel Diractor: After this certificate has been signed by the attending physicien a	iy tille	Gleal	29a. Certifier (Check only (C	sician: To the best of my know ner: On the basis of examination	rledge, death or	courred at the	time, date and place	, and due to the	cause(s) and manne	r as stated.
the H in 24 the Fu	nplete	w i	one)	and manner stated.	on and/or inves					```
To t	ro l	Σ	29b. Signature and title of certifier	2.0			S8303		29d. Date signed (M	onin, Day, Year)
			March	· >		1	3000		Wirty of	

State MAY 2 6 2006 Registrar



		•	1 - For State Registrar	Ciate of Maryland		tificate of L	Death		g. No.	UUb	10024	
П			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		Year	3. Time of Death	
	Physicia /Medic		Margaret Lofton	1				05	02	06	9:30 P M	
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		1	ounty of Death		
			Crescent Cities (Riverda If Under 1 Year		O Date of Bloth	P	rince G		
	Funeral Director	ĺ	5. Social Security Number 6. Sex 1240-38-0472	7. Age (In yrs. In 1985) 7. Age (In yrs. In yrs. In 1985) 7. Age (In yrs. In yrs. I	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		Count		
			Usual Residence of Decedent					07 06	21	North	Carolina	
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation	-			10	0d. Inside City Limits	
	e Ma	S	D.C	Wa	shingt	on					1 Yes 2 No	
	ith th	Director	10e. Street and Number			10f. Zip Code		10	0g. Citize	n of What Coun	try?	
	s 23a	rai	5011 14th. Street			20017	011070			USA		
	ltam.	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.\$ Armed Forces? 1 ☐ Yes 2X No	5. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spec n, Mexican, Puerto F	city Yes or No- lican, etc.)	14	Black, White, e		
2	urs eff	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		S	pecify: Blac	.k	
	s 1 and 2 should be filed within 72 hours efter death with the Maryland f Health and Menland Hygiene. I feel the mas 23a or 28a-f show then traumetic event, the Medical Examt serminates rividified at other traumetic event.	ted	15. Decedent's Edu		16a. Deced	lent's Usual Occupa	ation	_ 1	16b. Kind	of Business/Ind	lustry	
-	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	during most of workin)	g				
1	ygien ygien t. th	Cou	9th.			Domestic				vate		
2	2 should be filed within and Mental Hygiene. Is marked other than aumatic evant. The Market aumatic evant.	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		faiden St	umame)		
7	Mer Marke Marke	٦ ک	John Waddell	Dian	405 44-18			Inknown	01		2 11	
=	d2sthand thand 7 is n		19a. Informant's Name/Relationship (Ty		190. Mailin	g Address (Street a	and Number or Rural					
	1 and Health am 27 other tr		Doris Atkins/daug	20b. P	5011 ace of Dispo	14th. St sition (Name of	N.E. Wa	sh. D.C	20 Oc. Loca	017 ation - City or To	wn, State	
2	Pages nent of I ant: If its ary or of	1	1 Burial 2 Cremation 3 □R 4 □ Donation 5 □ Other (Specify)	emoval from State		natory or other place		08-06	1.1	2.11	NIC.	
			21. Signature of Funeral Service License	30		. Name and Addres	/// * 1		s Fu	neral Ho	ome	
č	permit. Departr Imports any Inj.		J.P. Marshall	Q P Marcha	el 4	217 9th.	St. N.W.					
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	oations that caused the death						D.U. 20	Approximate Interval Between	
4	Physician		Immediate Cause (Final disease or condition	Atherosc1							Onset and Death	
	/Medical		resulting in death)	Due to (or as a consequ		-						
	Examiner		Sequentially list conditions.)								
	sit ad	ine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequ	ience of):							
)"	rtificate be executed ng physician and s as the burial-transil	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):							
3	be e sician buris		d									
	ficate g physics the	Medical										
			IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna		T			23	d. Date of delive	ry	
	The law requires that the death ce ite has been signed by the attendi page 2 should be detached for use	Physician/	in the past 12 months? 1 \(\sumeq\) Yes 2 \(\overline{\mathbb{A}}\) No	1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown		Ectopic pregnancy Other (specify)				Month Day Year		
)	et the by th	hys	9 🗆 Unknown									
n n	res the igned be det	by	Part II. Other significant conditions con	_	_		en in Part I.				e cause of death?	
5	w requir been si should	ted	Hypertension Dial	oetes Mellitus	Туре	II		1 L Ye	s 2 🗆	No 3 Proba	ably 4∑Unknown	
מ	a law nas b e 2 sł	Completed	Dementia					24a. Was ar autopsy	/	prior to con	psy findings available npletion of cause of	
	rsiclan: The law s certificate has b lirector, page 2 s	Š						perform 1 Yes 2	X No	death?	2 No	
VILA	iclan certifi ector	Be	25. Was case referred to medical examiner?	fospital:		Othe	26. Place of Death			_		
5	Phys this ral dir	. To	1 ☐ Yes 2 🔀 No '	1 Inpatient 2	ER/Outpatien 28b. Time of	I SU DOA	4 K Nuising Hon	ne 5 Reside 8d. Describe ho)	
5	ding F h. After funer	ertification;	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Work		00. 00001100 110	w myany c	00001100		
2	Atten deal octor	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, str	eet, factory, office	2			Number or Rurai	I Route Number,	
5	al or s after of in b	Cert	4 Homicide	building, etc. (Specify	′)			City or Town	, State)			
	ospit hour unare ly fille			sicien: To the best of my kno								
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page	Medical	one)	ner: On the basis of examinal and manner stated.	aon and/or in							
	with to con	Σ	29b. Signature and title of certifier	MA		29c. License		29	o. Date	signed (Month, L	Jay, Year)	
	Q.		1 Cong	-170		DU 8	213		05-	-04-06		
	2		30. Name and address of person who co	,					0.5			
	* Sta	ntė.	Dr. Neelan Ashai 31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture 💉		over Hills	MD. 2	0784			
	Registr		31. Date filed (Month, Day, Year) MAY 2 6 2006	Block St.	Speak	٠.						
					-							

				1 - For State Registrar		State o	of Ma	ırylanı	-	artmen rtificat				lental Hy	giene	O	06	166	25
	1	Physici		Decedent's Name (First, Midd GAY						LIPPE	NS			2. Date of De MAY 22	ath	ე06	Year	3. Time of D	
		/Medio Examin		4a. Facility Name (If not institution HOSPICE OF BAL	n, give sti			IST				Location o	of Death			County		ΓIMORE	
ند		Funeral Director		5. Social Security Number 215-96-4536	6. Sex	M 27 F			ast birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir 06/08/	1962	4	9. Birthp Cour	lace (State or htry) MD	Foreign
10:25pm		the Maryland	or	Usuat Residence of Decedent 10a. State 10b. County MD B	ALTIN	MORF		10c. City	, Town or Lo	ocation IMORE							1	0d. Inside City	
0		with the Manager	Direct	10e. Street and Number 11 SLADE AVEN					D/L I	10f. Zip	Code	2120	18		10g. Citi	izen of W	hat Cour	ntry? USA	
9072-5	36	within 72 hours efter deeth with the Maryland ene. than "natural", or Itame 23e or 28e-f show he Modical Examinar must be notified at	by Funeral Director	11. Marital Status 1 X Never Married 2 Mar 3 Widowed 4 Divorces	nied 12	2. Was Dec Armed F 1 Tes If Yes, G Year or I	orces? 2XN ive			Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.))=		k, White,	an Indian, etc. WHITE	
5	21215-0036		Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	it's Educa	ation completed Cotlege (+)	(Give	dent's Usua kind of wo DO NOT u	rk done d se retired	tuning mos	t of worki	ing		ind of Bu	siness/In	dustry	
al a	Maryland 2	be file tal Hyg d othe	To Be C	17. Father's Name (First, Middle, RAYMOND	Last)				LIPP	ENS		18. Mothe		(First, Middle	, Maiden	Sumam	Θ)	GROLL	MAN
9		1 and 2 should I Heelth and Menitem 27 is market other traumatic		19a. Informant's Name/Relation RAYMOND LIPPE			ER			-				BALTIN					
ippens	altimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 1 □ Other (3)		moval from	State	_ a	tace of Disponentery, cre	matory or c	other plac) 25/20				own, State	
Lie	Baltir	permit. Pege Depertment of Important: if any Injury or once.		21. Signature of Funeral Service	-	ai	the	2 L	2	2. Name ar	nd Addres	s of Facili	y SO	L LEVII ROAD -	NSON	& B	ROS.	, INC.	
	8760, 1	/Medical Examiner photocology (he privile) transit	licai Examiner	23a. Part1. Enter the disease, o shock, or heart failure. Lis timmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	r complicitionly one a. b. c. d.	Due to	oach lin	consequ	uence of):		de of dying	g, such as	cardiac o	or respiratory a	rrest,			Approximate Interval Between Onset and De	eath
	P.O. Box 68	thet the death certifica led by the ettending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23		birth nant at	of pregna 2 Fetal time of de	death 3	⊒Ectopic pi ⊒ Other (sp						23d. Date Mor	e of delive	ery Day Ye	ear .
		quires thet I in signed by uld be deta	by	Part II. Other significant condit	ons cont	ributing to	death bu	ıt not resi	ulting in the u	underlying o	ause give	en in Part I		- Y	obacco u Yes 2			ne cause of decaded	
	al Reco	: The law requir cate hes been si page 2 should	Completed											24a. Was auto perfo 1 \(\text{Yes} \)		l p	rior to cor leath?	psy findings av mpletion of cau 2 No	vailable use of
	Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be	3 Suicide 6 Could	ng igation	28a. Date (Moi	e of Inju	Year)	ER/Outpatie 28b. Time o Injury ome, farm, st	of A	28c. Injury War 1 🗀 `	er: 4 □ Ni	ırsing Ho	me 5 Resi 28d. Describe 28f. Location (City or To	dence how injur	y occurre		N Route Number	
		To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	dicai C	29a. Certifier 1 Certify (Check only one) 2 Medica	ng Physi Examin	er: On the	ne best of basis of nner sta	examina	wledge, deal	th occurred nvestigation	at the tim	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s)	and mai place, a	nner as si and due to	tated. the cause(s)	
		To th within To th	Me	29b. Signature and title of certifit	3°	an						830			MA	Ya	I (Month, 3 みの	Day, Year) DOG	
		b		30. Name and address of person			use of de	eath (Item	1 23а) (Туре					RLES . 1D ZI		ET			
		Sta Regist	ate rar	31. Date filed (Month, Day, Yea. MAY 2 6) 1 90 6	Ben	Registra	ar's Signa	ture	de		•							

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d 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of nearth and mental hygiene. Important: If itsm 27 is marked other than "natural", or items 23s or 28s-f show	any injury or other traumatic event, the Madical Examiner must be natified a
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be	Department of negatificand mental hygiene. Important: If itsm 27 is marked other than	any injury or other traumatic eve
	Phy /N Ex	ysio led am	ciai lica ine
8760,	cate be executed	physicien and	the burial-transit

	Ph /I Ex	y: Vic	sic ed m	cia ica ine	n al er
DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	To the Hospital or Attending Physicien: The law requires that the death certificate be executed	within 24 hours after death.	To the Funerel Director: After this certificate has been signed by the attending physicien and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	
				5	+

	•	For State Registrar	State of Ma	ıryland		artment o			Mental H	lygie Reg.	-	06	16626
SHEET.		Decedent's Name (First, Middle, La	ast)						2. Date of				3. Time of Death
Physicia		Joseph J	ohn McGraw						Month May	21		Year 006	12:30 PM
/Medic Examin		4a. Facility Name (If not institution, gi				4b. City, Tov	wn, or Lo	cation of Dea			4c. County	of Death	
LXdiiiii		Mariner Health C	are of Lau	cel		Lau	ırel				Prince	e Geo	orge's
Funeral				(In yrs. la	st birthday)	If Under 1 Y		Under 24 Hr		Birth	2001	9. Birthp	lace (State or Foreign
Director		129-07-5850	X □M 2□F	87	Yrs.	Months D	ays I	Hours Min	March	30	1919	New	York
D		Usual Residence of Decedent											
nylan how Lat		10a. State 10b. County		10c. City,	Town or Lo	cation						1	0d. Inside City Limits
e Ma ia-f	cto	MD Prince	George's		Laurel	L							¥Yes 2 No
th th	Director	10e. Street and Number				10f. Zip Co	de			10g.	. Citizen of W	hat Coun	ntry?
23a		14200 Laurel Pa	rk Drive			2	20707	7			Ţ	JSA	
eme eme	Funeral	11. Marital Status	12. Was Decedent E Amed Forces?	ver in U.S	i. 13. V	Vas Decedent f Yes, specify	t of Hispa Cuban, M	anic Origin? (Mexican, Pue	Specify Yes or rto Rican, etc.)	No-		- Americ	an Indian, etc.
or It		1 Never Married 2 Married	1 ☐ Yes 2/CXN	0		I∐Yes 25		Specify:				Whi	
ural'.	d by	3 Widowed 4 Divorced	Year or Dates:									_	
"nat	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		16a. Deced	lent's Usual O kind of work o DO NOT use r	one duri	n ing most of wo	orking	161	b. Kind of Bu	siness/Inc	dustry
withir ane. than	E	Elementary/Secondary (0-12) 8th	College (1-4or 5	+)		holste				- E	rurnitu	ıro	
Hygir ther int,	Ö	17. Father's Name (First, Middle, Las			10	JIOISCE		3. Mother's Na	ame (First, Mide				
notal ed o) Be	John McG	•						lie Rey			-,	
hould Me Me mark	ဥ	19a. Informant's Name/Relationship			19b Mailin	n Address (Si	treet and		Rural Route Nur			State Zin	Codel
d2s than t7s trau		Gregory S. Karp							aurel,			3.u.o, 2.p	0000)
1 an Hea Hea Ism 2		20a. Method of Disposition	man/ Filenc	20b. Pla	ace of Dispo	sition (Name	of	nue, I	Date Date		20707 c. Location - (City or To	wn, State
ages nt of t: If if		1 ☐ Burial 2 ☑ Cremation 3 (natory or other		5 /2	1 /2006				
urtme ortani njun		4 □Donation 5 □Other (Spec 21. Signature of Funeral Service Lice		west		del Cr			31/2006		denton	<u> </u>	ne, P.A.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, It's Medical Exemitier must be milified at once.		1/////	1//	00773	1				ie, Lau:			20707	•
3		23a. Part1. Enter the disease, or cor										20707	Approximate
		shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	е.						, 411 001,			Interval Between Onset and Death
Physician / /Medical		disease or condition resulting in death)	a			ate W/	Met	astasi	.s				over 1 yr
Examiner			Due to (or as a	conseque	ence of):								
2.4	6	Sequentially list conditions, if any leading to immediate	b. Due to (or as a	conseque	ence of):								
nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
al-tra	xai	that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):								
The law requires thet the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burral-transit	dicai		d										
ficate phy s the	edic		0.										
eath certifi attending I I for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date	of delive	rv.
Jeath a atte	Physician/M	in the past 12 months?	1 Live birth 4 Pregnant at			Ectopic pregr Other (specif				-	Mon	th	Day Year
the c	Jysi	9 Unknown	9□ Unknown										
res thet the de signed by the a f be detached i	by PI	Part II. Other significant conditions	contributing to death bu	it not result	ting in the ur	nderlying caus	se given ii	n Part I.	23e. Di	d tobac	co use contri	bute to th	e cause of death?
quires n sign	d b	Arteriosclero	cic Cardiov	ascul	ar Di	sease			1[Yes	2 🗆 No	3 🗌 Prob	ably 4x Unknown
w require been sig should b	iete								24a. W	as an	24b. W	/ere autor	osy findings available
sicien: The faw certificate has b irector, page 2 s	ompieted								pe	topsy rformed	d? de	rior to con eath?	npletion of cause of
	Ö	25. Was case referred to medical						S Place of De	1 Ye		No 1	☐ Yes	2 X No
Attending Physicien: or death. ector: After this certific by the funeral director.	OB	examiner? 1 ☐ Yes 2XXNo	Hospital: 1 ☐ Inpatie	nt 2∏E	R/Outpatien	t 3 DOA	0.1		eath <i>(Check on</i> Home 5 ☐ Re		o e Motho	r /Canada	
Phys er this eral di	-	27. Manner of Death	28a. Date of Injur	y 2	28b. Time of		Injury at Work?				injury occurre		7
After Section 19	to	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	rear)	Injury	М		2 🗆 No					
Atter r dea octor by the	HICE	3 ☐ Suicide 6 ☐ Could not	28e. Place of Inju	ry - At hon	ne, farm, stre	eet, factory, of	ffice					r or Rura	l Route Number,
s afte	Certification:	4 Homicide determined	building, etc	. (эрөспу)					City or	rown, S	iaf9)		
To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.		29a. Certifier X Certifying P	hysician: To the best of	f my know	ledge, death	occurred at t	he time, c	date and plac	e, and due to the	ne caus	e(s) and mar	ner as st	ated.
ne Hk	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examination ted.	on and/or inv	estigation, in	my opinio	on, death occ	curred at the tim	e, date	and place, a	nd due to	the cause(s)
To the To the To the Comp	ž	29b. Signature and title of certifier	A P			29c. Li	icense nu	umber		29d.	Date signed	(Month, I	Day, Year)
-			TO	1 N	1:1	D	2472	1			May	24,	2006
2		30. Name and address of person who	completed cause of de	ath (Item 2	23a) (Type,					1	2		
0		Syed Sadiq,	14333 Laur	el-Bo	wie R	nad La	aure	1, MD	20708				
Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	ire	00		,	20,00				
Registr	ar	MAY 2, 6, 2006	Pol 2	150	A TABLE								

State of Maryland / Department of Health and Mental Hygiene 1 - State Registre Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ERVIN **Physician** 6:30 PM IAY 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Loch Raven Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Min 1⊠M 2□F Yrs. 251-20-9382 90 Feb 8, Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or Items 23e or 28e-1 show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State traumatic evant, the Medical Evanduer must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Perry Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21128 4925 Tartan Hill Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: 3 Widowed 4 Divorced II white 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk College (1-4or 5+) Elementary/Secondary (0-12) Engineer unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Betty Brown Mayer Orem Malinow 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4925 Tartan Hill Road Perry Hall, MD 21128 itam 27 Donald Malinow/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If its any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signalus of Funeral Service Licensee Ronal d S. Wade win Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lijle. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or w a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐ Unknown detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2. No 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 1 No 2 this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Certification: Injury 1 Natural 5 Pending 2 No 1 Yes investigation death. 2 Accident Diractor: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Continuous of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and ille of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven 0 OC Registrar's Signature 31. Date filed (Month, Day, Year) State 2 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistra Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:30 AM May 23, 2006 Patricia Ann Mulloy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center for Hospice Care Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/13/1932 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 73 Yrs. ŴΙ 390-28-9787 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State 28e-1 show Examiner pust be notified at 1 ☐ Yes 2 No Columbia Director MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23e or 21046 United States 10222 Donleigh Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🗖 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify White Baltimore, Maryland 21215-0036 ō Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: if item 27 is marked othe eny injury or other treumetic event, ODGs. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Tda Unknown Ray Ries 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10222 Donleigh Drive Columbia, MD 21046 George Mulloy/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 24 May 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 2006 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rear Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit attending physician and Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day Month in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MMy 23, 2006 6601 N. CHARLES STREET 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 TOWSON, MD 21204 32. Registrar's Signature 31. Date filed (Month 6 2006 State Registrar

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			Registrar 1. Decedent's Name (First, Middle, Last)	Reg. 2. Date of Death	No. 3. Time of Death
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	/Medic			-	26 2006 7/5/4M 4c. County of Death
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			5. Social Security Number 6. Sex 7. Age (In yrs lax birthday) If Under 1 Year If Under 24 Hrs.	9 Date of Birth	9. Birthplace (State or Foreign
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	the 28a	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	With Sa or	<u> </u>	5610 Greenhill Road 21206		USA
	be filed within 72 hours after death with the Maryland Hygiene. Id either then "natural", or items 23a or 28a-f ehow to other then "natural", or items 23a or 28a-f ehow avent, the Mcdical Examinar must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - American Indian,
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	1 and 2 Health a tem 27 ls	Н	Judith Eskey - daughter 5610 Greenhill Road, Ba	ltimore,	MD 21206
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ä	Department of the partment of		21. Signature of Funeral Service Licensee MO0986 ZAFA, Stephen D. Lo	nrmann, E Drive. T	Towson, MD 21286
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	Sta Registi		31. Date filed (Month, Day, Year) MAY 2 6 2006 Registrar's Signature		
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3			EW COLG 3	IT AGNE	2	900	CAT	3N:1	AVE	SA	LTIME	DIE	MD	21229
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year May 11, Physician 2006 5:03 A M Catherine Anderson Morse /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Gaithersburg Montgomery 10824 Eberhardt Drive If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Jan. 23, 9. Birthplace (State or Foreign Country)
Connecticut 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🕅 F Jan. 57 045-42-1326 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. Count 28a-fehow rthen "naturel", or items 23a or 28a-f ehov tre Madical Examiner must be notified at 1 ☐ Yes 2 X No Gaithersburg Maryland | Montgomery Directo 10g. Citizen of Whal Country? 10f. Zip Code 10e. Street and Number 20879 United States 10824 Eberhardt Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status within 72 hours efter 1 Never Married 2 Narried 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) is 1 and 2 should be filed with of Health and Mental Hygiene. Item 27 is marked other them **IBM** Data Base Administrator 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Arther Anderson Carmela Martino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 10824 Eberhardt Drive, Gaithersburg, Maryland 20879 Robert Morse/Husband 20b. Place of Disposition (Name of competery, crematory or other place)
Montgomery 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
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Importent: if ite
eny injury or of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 18,2006 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 21. Signature o Funeral Service Licensee 22 Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. DUC M00198 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediale Cause (Final disease or condition resulting in death) 5 Years Multi System Atrophy **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and I-transit or Attending Physician: The law requires that the deeth certificate be executed Due to (or as a consequence of): physicien a s the burial-#33 Division of Vital Records, P.O. Box 68760, ician/Medicai ettending for use as IF FEMALE 23c. If yes, outcome of pregnancy

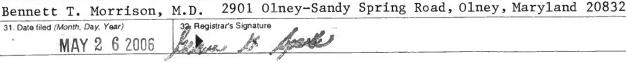
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☒ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Physi 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ s efter de... this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27 Manner of Death Certification: Injury 1 XNatural 5 Pending 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in within 24 hours e To the Funeral C Hospital t 🔯 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier - Mourison is Bennett D47682 May 11, 2006

State Registrar

MAY 2 6 2006

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Maryland 21215-0036

Saltimore,

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Menchion 7:35PM M May 22, 2006 Alchester /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Landover 7529 Courtney Place If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept. 2,1936 9. Birthplace (State or Foreign F1011) a 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. Months 1 ☑ M 2 □ F 69 263-46-6719 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a, State show r than "natural", or items 23a or 28a-1 show the Medical Examiner must be extilined at 1 ☐ Yes 2 🕅 No Landover Prince George's Directo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20785 7529 Courtney Place death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 MXes 2 □ No 195 ff Yes, Give Year or Dates: 197 14. Race · American Indian. 11 Marital Status Black White, etc. African filed within 72 hours after 1954-1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: American Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced 1976 Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Computer Tech. Computers 12th event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other treumatic event 900g. Donaldson Lillie Mae Alex Menchion 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7529 Courtney Place Landover, Maryland 20785 Sandra Menchion (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) May 30. 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2006 Cheltenham, Maryland Maryland Veterans Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 011 21. Signature of Funeral Service Licensee Alexandria Ferry Road, Clinton, MD moiz84 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 18 Months Renal Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of): Examine Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, by Physiclan/Medical as the 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2√0 No 3 Probably 4 Unknown been si To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1□ Yes 2↓No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 3□ DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Division or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitei XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D18219 May 24, 2006 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Staal, M.D. 1221 Mercantile Lane, Largo, MD 20774 Apgistrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 6 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		14	For State Registrar	State of Maryland		rtment of Hotificate of L			giene) (16 166	533
			1. Decedent's Name (First, Middle, Last			h. /	/	2. Date of De	ath	3. Time o	of Death
	Physici	_	BEORGE			1131	SON	Month	23 2	Year 506 17	1/ M
	/Medio Examir		4a. Facility Name (If not institution, give	street and number) /		4b. City, Town, or	Location of Death	777	4c. County	100	
н	LAGITIT	Ĭ	The Johns How	Vix Hospil	1	Bulti	MARIE		27 /2		
	Funeral		5. Social Security Number 6. Se		si birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h N/A	9. Birthplace (State	or Foreign
	Director		212-20-6475]M 2□F 80	Yrs.	Months Days	Hours Min.	(Month, Da	B, 1925	Country) Maryland	
	D		Usual Residence of Decedent							7 2 01210	
	how		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside C	•
	e Ma	cto	Maryland Baltim	ore D	undal)	ς				1 U Yes	s 2√2 No
	ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?	
	23a		7504 Holabird Ave	nue		21222			United	States	
	ams arr	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		Vas Decedent of Hill Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. Race Black	- American Indian, c, White, etc.	
9	or if		1 Never Married 2 Married	1 ☐ Yes 2 ⊋No If Yes, Give		☐ Yes 2☐No	Specify:		Specify:		
ë	d within 72 hours after death with the Maryland liene. r then "natural", or Itams 23a or 28a-f show The Medical Exactinat canal be incilled at	d by	3 XWidowed 4 Divorced	Year or Dates:						MILLCE	
က်	"nat	Completed	15. Decedent's Edu (Specify only highest grad		(Give	lent's Usual Occupa kind of work done d DO NOT use retired,	furing most of wor	king	16b. Kind of Bu	siness/Industry	
21215-0036	withii ene. then	E	Elementary/Secondary (0-12)	College (1-4or 5+)		,					
	TI TO SE		11 years 17. Father's Name (First, Middle, Last)		Steel	Worker-			Stee		
Maryland	B d a b	Be		~						-7	
2		2	George E. Nelson, 19a. Informant's Name/Relationship (T)		10h Mailin	g Address (Street a	Muriel Mumber or Bu			State Zin Code)	
∑	Tan P	1 15	Darlene R. Gaston								
	1 an Heal em 2		20a. Method of Disposition	(Daughter)	ce of Dispo	sition (Name of		Dundal		land 21222 City or Town, State	2
Baltimore,	Some		1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	metery, cren	natory or other place	1				
語	rtmer rtant	1	* 4 Donation 5 Other (Specify, 21. Signature of useral Service Licens	Juli		Cemetery Name and Addres		6/2006	Baltimo	re, Maryla	ınd
Ba	permit. Page Department of Important: if any injury or once.		21. Signature during all Service Licens		Ι	uda-Ruck	Funeral	Home of	Dundal	Inc.	
			220 Part Enter the disease or come	lications that caused the death		'922 Wise	Avenue	Dundalk	. Maryla	and 21222 Approxima	ato.
ll.			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each line.	Do not ent	er the thode of dying	g, such as cardiac	or respiratory a	1621,	Interval Be Onset and	etween
	Physician	4	Immediate Cause (Fixal disease or condition resulting in death)	· Multiple D	RGAN	1-A-14P	E			4 dA	45
В	/Medical Examiner		resulting at deality	Due to (or as a conseque	ence of):					- 1	/
		L	Sequentially list conditions,	b. SEVS S Due to (or as a conseque						549	45
_	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury	Duello (oi as a conseque	erice or):	Tr	No.			- 10 1	
73.	and I-tran	хап	that initiated events resulting in death) Last	c. 4 () 4 () 4 () ue to (or as a l'onseg	ence of):	- Inta	9 t. O-1			10 1	245
8760,	The law requires that the death certificate be executed ite has been signed by the attending physiclen and page 2 should be detached for use as the burial-transit										•
87	physic the l	dlcal		d						- 1	
9 x	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregnan	cv				201.0		
Вох	atten for us	lan	in the past 12 months?	1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3	Ectopic pregnancy			23d. Date Mor	of de livery oth Day	Year
o.	t the de by the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	atn 5∟	Other (specify)					
Q	that the by detac		Part II. Other significant conditions co	ntributing to death but not resul	ting in the u	nderlying cause give	on in Part I.	23e. Did t	obacco use contr	bute to the cause of	death?
Records,	ires tha signed d be de	i by	•	····- -		,		1(1)	Yes 2□No	3 ☐ Probably 4 ☐	Miknown
Ö	w require been si should I	Completed			_			-			
ec	e law hest	ldu				_		24a. Was	osv p	Vere autopsy findings rior to completion of eath?	available cause of
E.		Co						1 ☐ Yes	rmed? d 2. No 1	Yes 2 No	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hogoital:		0.11	26. Place of Dea	th (Check only o	nne)		
of	Physic this c	2	1 105 2 2 10		R/Outpatier		4 🗀 i dui sing i i		dence 6 □Othe		
n o	ding P	on:	27. Mann → f Death 1 ☐ latural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe I	now injury occurre	ed	
Division	eath tor: / the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No				
≥	fter d irec n by	Ħ	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, str	eet, factory, office		281. Location (: City or Tox	Street and Numbe vn, State)	or or Rural Route Nur	n <i>ber</i> ,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer			1				<u> </u>			
	Hosp 14 hou Fune ely fi	ica	(Check only 2 Medical Exam	sicien: To the best of my know iner: On the basis of examination	vledge, death on and/or in	occurred at the time restigation, in my op	ie, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause((s)
)	the hin 2 the nplet	Medical	one)	and manner stated.		29c. License					
	To To	-	29b, Signature and title of tertifier			1 -				(Month, Day, Year)	
•	ر.		1 XX	M.	>	KOS-	-000	/	11/4 2	4 2006	
	S		30. Name and a sess of person who o	ompleted cause of death (Item	23a) (Type,	Print)	- 01	1211.		4 2006 Pary part 2	
_			C'HRISTOPHOR KS	EURSIMD LOU	N	WOIFE	2 St. 1	OHITIM	10RZ, 111	aly And I	1281
		ate	31. Date filed (Month, Day, Year) MAY 2 6 2	32. Hegistrar's Signati	ure	asti I				/	
	Regist	rar	MAI & OZ	100 Replace L	10000	- S-3-					

			For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment of F	lealth and N Death		giene) 6	166	34
		2	Decedent's Name (First, Middle, L.	ast)					2. Date of Dea	th		3. Time of	Death
	Physicia		William Wal	lace	Norton,	Sr			Month May	Day 20	Year 006	8:45	PΜ
	/Medic Examin		4a. Facility Name (If not institution, gr	ve street and n	umber)		4b. City, Town, o	r Location of Death		4c. County	of Death		
1	LAGITIII	ر. ج	10517 Scaggsvi	lle Roa	d		Laure	1		Howan	d		
	Funeral		Social Security Number 6.	Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or	r Foreign
	Director		217-20-5871	1 ⊠ M 2□F	80	O Yrs.	Months Days	Hours Min.	April 3	0 1926	III	inois	
	2 -		Usual Residence of Decedent		10.0							104 114- 01	. 11
	arylar show dat	<u>_</u>	10a. State 10b. County			ty, Town or Lo	cation			,		10d. Inside Cit 1 ☐ Yes	-
	Ba-f s	cto	MD Howard			Laurel							\$4XIII
	1 or 2	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Cou	ntry?	
	23a	ra .	10517 Scaggsvi				207			US			
	tams	une	11. Marital Status	Armed F		J.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Hace Blac	· Amen k, White,	can Indian. etc.	
2	or l	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes If Yes, G	2 □ No live		1 ☐ Yes 2 🗓 No	Specify:		Specify.	Wh	nite	
	ural		15. Decedent's	Year or	Dates:	16a Dagge	dent's Usual Occup	ation		16b. Kind of Bu	0.0000/10	duota	
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7	withi ene. than	Ĕ	Elementary/Secondary (0-12)	College 5+	(1-4or 5+)			e Manager		Westir	ahor	190	
3	filed Hygi ther ant, 1		17. Father's Name (First, Middle, Las			11 Gillian	RODOULO	18. Mother's Nam				ADC_	
ylallo	d be antal	o Be	Howard Emerson	Norton				Sophia	Elizabet	h Dorba	nd		
<u></u>	mari	ဥ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street	and Number or Ru				Code)	
2	id 2 s Ith ar 27 is trau		William W. NOrt		/ Son			fied Lane					2
בֿב	Hea Hea tem		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name of	1	Date	20c. Location -	•		
2	ages ont of t: If I		1 ☑XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		n State	-	natory or other places S Cemete:	1	/2006	Fulton,	MD		
allillo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show appringute or other traumatic avent, the Medical Exacting mantitle rediffed at once.		21. Signature of Funeral Service Lice		DC.		2. Name and Addre	arts	onaldsor			me. P.	Α.
Ö	permi Depa Impo eny it		Daminos	mans	(, M0110)3	313 Talb	ott Avenu			2070		
3			23a. Part1. Enter the disease, or co shock or heart failure. List on	nplications that	caused the dea	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate	9
			shock or heart failure. List on Immediate Cause (Final	y one cause on								Onset and D	Death
<i>k</i>	Physician /Medical		disease or condition resulting in death)	a	Prostat o (or as a consec		er Metas	tatic to	Bone			2 year	S
	Examiner			D00 10	o (or as a consec	querice or).							
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,	exec n and ial-tra	Exa	resulting in death) Last	Due to	o (or as a consec	quence of):							
0 / o	death certificate be executed e attending physicien and nd for use as the burial-transit	dical		d									
g	ifficat g phy as th	ed		-						1			
ZOD	res thet the death certific igned by the attending p be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		Ectopic pregnance			23d. Date	of deliv	егу	
מ	death e atte d for	icia	in the past 12 months? 1 □ Yes 2 □ No	4□Pre	gnant at time of o		Other (specify) _	у		Mor	ith	Day Y	'ear
2	t the by the ache	hys	9 □ Unknown	9∐ Unk	nown								
L	requires thet the leen signed by th hould be detache	Ϋ́	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contr	ibute to t	he cause of de	eath?
ğ	w require been sig should b		Congestive	Heart F	ailure				1 □ Y	es 2 X No	3 🔲 Proi	bably 4 □U	nknown
Records	¥ 0 8	ojet	Anemia						24a. Was		Vere auto	opsy findings a	available
Ĕ	nysician: The lav nis certificate hes I director, page 2	ompieted							autop perfor	med? d	rior to co eath? Yes	mpletion of ca 2√2√No	luse of
VII	an: tifica tor, p	C	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes			ZAM	
	Physician: this certific ral director,	0 0	examiner? 1 ☐ Yes 2 ☐XNo	Hospital: 1	Inpatient 2] ER/Outpatier	nt 3□ DOA Ot	200	ome 5 🔀 Resid		r (Specii	fv)	
0	m ∓ m	L.	27. Manner of Death	28a. Date	e of Injury onth, Day Year)	28b. Time o	f 28c. Injur	ry at	28d. Describe h			,,	
DIVISION	r Attending Fist death.	atlo	1XXNatural 5 ☐ Pending 2 ☐ Accident investigat		min, bay row)	Injury		Yes 2 □ No					
<u> </u>	Atte	tiffe	3 ☐ Suicide 6 ☐ Could not determine	d 280. Plac	ce of Injury - At h		eet, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	or Rura	al Route Num	ber.
5	spital or ours afte neral Dir filled in	Certification:			dirg. die: \open	.,,,							
	To the Hospital or Attendi within 24 hours after death. To tha Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying I	hysician: To the	he best of my kn	owledge, deat	h occurred at the til	me, date and place	, and due to the o	ause(s) and ma	nner as s	stated.	
	To the Hos within 24 h To the Fun completely	ledical	one)	and ona	inner stated.								
	To 1	Σ	29b. Signature and title of certifier	V	V		29c. Licens	se number		29d. Date signed	(Month,	Day, Year)	
)	1		P Cyon'h. 11	1 m	NE Y) ,	D3	30573		May 2	6, 2	006	
	15		30. Name and ddress of person wh	o completed ca	use of death (Ite	m 23a) (Type,	Print)						
	1-		John Minford,				ent Parkv	vay, Colu	mbia, MD	21044			
100	Sta		31. Date filed (Month, Day, Year)	<u> 2</u> 2.	Registrar's Sign	ature	de 1						
1	Registi	rar	MAY 2 6 200	6 100	Com St	14 Marie							

			for State Registrar	State	of Maryl	and / Depa <i>Ce</i>	artment of H rtificate of L	lealth and I Death	Mental H	lygiene Reg. No		16635
			1. Decedent's Name (First, Midd	fle, Last)					2. Date of	Death		3. Time of Death
	Physici		Jim Henry	Nelso	n, Jr.				Month 05	Da 1 3	•	17:30 M
	/Medio Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of Death			County of Dea	
	LXamii		Holy Cross H	ospital			Silver	Spring			Montgo	m O 1evr
	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of	Birth	Montgoi 9. Bi	rthplace (State or Foreign
	Director		239-40-8710	1⊠M 2□F	73	Yrs.	Months Days	Hours Min.		Day, Year)		ountry) rth Carolina
	ס		Usual Residence of Decedent		, , ,					_رر	INO.	LLII Carorria
	ylan how		10a. State 10b. Count	•		. City, Town or Lo						10d. Inside City Limits
	Ma P-1-8	Director	MD. Princ	e Georges		Beltsvil	le					1√2 Yes 2 □ No
	h the	ire	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What C	ountry?
	15 wi		11236 Evans T	rail #104			20705			τ	JSA	
	dee	Funeral	11. Marital Status		ecedent Ever i	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S)	pecify Yes or		14. Race - Am Black, Whi	
Q	or It	王	1 Never Married 2 Ma	rried 1 Tyes	2 XNo		1 ☐ Yes 2 🖫 No	Specify:	o moun, etc.)		Specify: B1	•
2-002p	ours ral',	d by	3 ☐ Widowed 4 ☐ Divorce	d Year or			TE 163 ZIMAO	Зреспу.			Specify: D1	ack
ก็	within 72 hours after deeth with the Maryland ene. then "natural", or Iteme 23s or 28s-f show the Medical Examiner must be inclifted at	Completed	15. Decede (Specify only high	nt's Education est grade completes	d)	(Give	dent's Usual Occupa	luring most of wor	kina	16b. K	ind of Business	/Industry
V	ithin	du	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retired)				
V	e filed within at Hygiene. I other then "	Ö	8th.			Gara	ge Manage	r			cal Uni	on 272
yrand	d oth	Be	17. Father's Name (First, Middle	, Last)				18. Mother's Nam	ne (First, Midd	dle, Maiden	Sumame)	
Ž	should be nd Mental marked o	ဥ	Eli Nelson					Floren	ce Par	ker		
ā	ds = m		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Nur	nber, City o	or Town, State.	Zip Code)
≥	1 end 2 Heelth 6 em 27 i		Lillie Nelso	on		1123	6 Evans T	rail #10	4 Belt	sville	e. MD.	20705
	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 DRomoval fra		 b. Place of Dispo 	sition (Name of matory or other place		Date	20c. Lo	ocation - City or	Town, State
Ĕ	Pag nent int: I		4 □ Donation 5 □ Other (fetropol:	itan	05-2	3-06	Alex	kandria	, VA.
baltimo	permit. Pages 1 Depertment of H Importent: If Ite any Injury or ot once.		21. Signature of Funeral Service	Licensee			2. Name and Addres	s of Facility MA	rshall			
מ	Depermine Deperm		Pma	uha 00	•	42	217 9th. 9	St. N.W.	Washir	gton,	D.C. 2	20011
Н	-		23a. Part1 Enter the disease, of	r complications that	caused the c	leath. Do not ent	er the mode of dying	g, such as cardiac	or respiratory	arrest,		Approximate
	Physician		shock, or heart failure. Lis Immediate Cause (Final	•								Onset and Death
	Physician /Medical		disease or condition resulting in death)		ptic S							
	Examiner				o (or as a con	sequence or):						
		-	Sequentially list conditions,	b. Se	psis o (oras a con	se vience of						
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h	and al-tra	xar	that initiated events resulting in death) Last		eum ni. o (or as a con						_	
9/00,	cate be executed physicien and the burial-transit	<u>ea</u>			,	•						
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S S	ding ding	Me	IF FEMALE:	220 If yes s	urtoomo of oro	an an an					77	
2	The law requires thet the death certifi ate has been signed by the attending page 2 should be deteched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	outcome of pre birth 2 F	etal death 3	Ectopic pregnancy			4.8	23d. Date of de Month	livery Day Year
- -	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pre- 9□Unk	gnant at time i nown	of death 5	Other (specify)			-	WOTE	Day . our
Ľ	d by	F.		iono contribution to		lain - In Ab			00 - D			
Ś	igne be d	Ď	Part II. Other significant condit	ions contributing to	death but not	resulting in the u	nderlying cause give	n in Part I.	100			the cause of death?
2	equi	Completed	Respir	atory Fai	lure				11	JYes 2X	CINO 3 I P	robably 4 Unknown
5	law ras be	ple							24a. W	as an topsy	24b. Were a	utopsy findings available completion of cause of
_	: The law cate has t page 2 s	ě							pe 1 ☐ Yes	rformed?	death?	2 No
ā		Be	25. Was case referred to medica	al				26. Place of Deat		-	12,100	20110
>	Attending Physicien: r death. sctor: After this certifici	70	examiner? 1 ☐ Yes 2 ☐No	Hospital:	Inpatient 2	2 ☐ ER/Outpatien	t 3 DOA Cthe				6 ∏Other (Spe	cify)
5	g Ph erth erat		27. Manner of Death		e of Injury onth, Day Year	28b. Time of	28c. Injury Work		28d. Describ			
	ndin ath. r: Aft	ate	1 □Natural 5 □ Pendi 2 □ Accident invest	ing (***C	min, Day 19a	r) Injury		es 2 □No				
2	Atts r deg ecto by th	ij	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	mined 288. Plac			eet, factory, office		28f. Location	(Street an	d Number or R	ural Route Number,
5	effe effe Dir	Certification;	4 Homicide	Duil	ding, etc. (Sp.	өсіту)			City or I	own, State)	
	spitu nours nere		29a. Certifier 1 Certifyi	ng Physician: To ti	ne best of my	knowledge, death	occurred at the time	e, date and place,	and due to th	e cause(s)	and manner as	s stated.
	To the Hospital or Attanding Physicien: within 24 hours effer death. To the Funerel Director: Affer this certific completely filled in by the funeral director,	edical	(Check only 2 Medica one)	ing Physician: To to I Examiner: On the and ma	basis of exam inner stated.	nination and/or inv	vestigation, in my op	inion, death occur	red at the time	e, date and	place, and due	to the cause(s)
	Vithir Somp	Σ	29b. Signature and title of certific	er 4	0		29c. License	number		29d. Dat	e signed (Mont	h, Day, Year)
			•	the	-, /	42	۸۵۵63	27.2				
	2		30. Name and address of persor	who campleted on	use of death /	Item 23a) (Type	A00-63	1343		05-	16-06	
	3							1 170 m C	ine M	`		
	Sta	te	Dr. Irina Ruba 31. Date filed (Month, Day, Year) A 32.	Registrar's Si	gnature /	en Nu. 51	iver Spr	riig, M	<i>)</i> •		
	Registr		MAY 2 6 20	006	Jos Jos	gnature						

State of Maryland / Department of Health and Mental Hygiene 0 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 05 2008 7:30а м Kenneth Frederick Osborne /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4255 Southern Ave Capitol Heights Prince George If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth 05-27-21963 7. Age (In.yrs. last birthday) 9. Birthplace (State or Foreign New Brockton AL **Funeral X** M 2□ F 579-02-0305 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ul Hygiene. other than "natural", or Itama 23a or 28a-f ehov vent, the Madical Examinar must be notified at MD Prince George 1 Yes 2 No Capitol Heights Director 10e. Street and Number 10f. Zin Code 10g. Citizen of Whal Country? 20743 4255 Southern Ave permit. Peges 1 and 2 should be filed within 72 hours after death 1 Deperment of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or itema 23e eny hijury or other treumatic event, the Medical Examiner must.) Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZÃNo If Yes, Give Year or Dates: 11. Marital Slatus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Ŕ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Barber Hair Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hattie Lee (Gunn) Osborne Herman James Osborne Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2405 Darel Dr. #102 Suitland, MD 20746 Danielle Price/niece 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other of Date 20c. Location - City or Town, Slate 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05-24-2006 Chesapeake Crematory Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Rapp Funeral & Cremation Service
933 Gist Ave Silver Spring MD 20910 MU 358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) SUDDERO DEATH-CARDIAC ARRAYTHULA. **Physician** /Medical Due to (or as a consequence of): Examiner END-STAGE RENAI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed HYPERTEUSION Division of Vital Records, P.O. Box 68760, NEPHROPATHY Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant al time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificete hes b lirector, page 2 si 24a. Was an autopsy performed? Yes 200 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🚉 No ۵ 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation death. 1 TYes 2 No d in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours eff To the Funeral Di completely filled in is Certifying Physician: To the heat of my knowledge death occurred at the time date and place, and due to the cause(s) and mainter as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 4385 5-23-2006 3 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 20037 2150 PENNSYLVANIA AUF NW washintas De MANUEL VELASQUEZ 31. Date filed (Month, Day, Year) 32. Flogistrar's Signature

State

Registrar

MAY 2 6 2006

Amend item 6 per fh 8855 5-26-06 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 4:02 PM MAU K DWGND DNEILL 21 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MANYCAM BANMONE MARDICAL CONTRA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6 Sax Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 20≸F 104-28-7901 69 July 30,1936 New York, NY **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show other treumatic event, the Medical Examiner must be notified at NY Nassau Syosset 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 11791 25 Cedar Street USA 238 Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: items. Black, White, etc.
White Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status be filed within 72 hours after 1 ☐ Never Married 2 Married ŏ Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Law Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of Edward O'Neill Loretta Joyce Pages 1 and 2 should ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Clare O'Neill /Wife 25 Cedar Street Syosset, NY 11791 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 26, 20c. Location - City or Town, State permit. Pages I Department of F Important: If its eny injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Valhalla, NY Cate of Heaven Cemetery 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Ave. Baltimore MD 21230 21. Signature of Funeral Service Licensee or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, set only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician HUPOXIA /Medical Due to (or as a consequence of): Examiner DAYS DIMONUBING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Leukemi a MONTHIS ACUTE PLYELO DENOIS Due to (or as a consequence of): 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐ Unknown Month 5 Other (specify) detached o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page 1 ☐ Yes 2 XNo To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No ot funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 119646 21 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. AENAHAN RAMMON 5, Creamy 21201 mongeron MICHAEL 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 2 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 22, 2006 11:40 P M **Physician** Rose Ann Pacunas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Good Samaritan Nursing Home Il Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 0 CTODE | 0 , 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 1 F Marviand 86 214-40-5920 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location Health and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23s or 28e-1 show other traumatic event, the Micalcal Examiner must be multied at 1 Yes 2 □ No Mary land Baltimore N/A Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21239 1601 E. Belvedere Avenue Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Specify: White 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 3√ Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Gollege (1-4or 5+) Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anne Regina McGovern John Bernard Nichols 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 208 Worthmont Road Catonsville Maryland 21228 Fran Cannon/Daughter 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition ō <u>=</u> 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Maryland 5/25/06 New Cathedral Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Physician /Medical Due to (or as a consequence of): Examiner 6 weeks Pressure Ulcer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine malnutrition 6 months or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, a years Dementia Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 HNo 3 ☐ Probably 4 ☐ Unknown Heart failure lung disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an stenosi's 1 ☐ Yes Spinal 25. Was se referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Surring Home 5 Residence 6 Other (Specify) 1 Yes 2 Yo ٥ this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification; After 1 Alatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 | Homicide within 24 hours at To the Funerat D completely filled i 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ** Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier may 23, 2006 D46504 who completed cause of death (Item 23a) (Type, Print)
ey, MD Good Samaritan Hospital, Baltimore, MD 21239 30. N me and address of pe so

DHMH 17 Rev 1/2001

State

Registrar

Nancy Fri

6 2006

32. Registrar's Signature

			For State Registrar	State of Marylar			nt of Health te of Deat			giene (306	16639
			Decedent's Name (First, Middle, Last)						Date of De	ath		3. Time of Death
	Physicia /Medic		Jean M. Pisanic					1	n Ay	23	3006	3:50AM
9	Examin	le le	4a. Facility Name (If not institution, give str	eet and number)		4b. City	, Town, or Location	on of Death		4c. Co	ounty of Death	
			ST. AGNES HO	SMITHL		B	ALTIMO	RE			n/a	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. 84	last birtha Yrs	Months			(Month, Da	y, Year)	Cou	place (State or Foreign intry)
<=	Director		209-12-7073 Usual Residence of Decedent	04				<u> </u>	lov 14	, 1921	Penns	sylvania
	yland		10a. State 10b. County	10c. Cit	ty, Town o	r Location						10d. Inside City Limits
	#-1 sl	ctor	Maryland Baltimore		Ca	atonsv.	ille					1 ☐ Yes 2X No
	ith th	Olre	10e. Street and Number			10f. Zi	p Code			10g. Citizer	n of What Cou	ntry?
	ath w	Funeral Director	1400 Hallwood Road				21228				ted Sta	
	er de Itemi	nne		. Was Decedent Ever in U Armed Forces?	1.S.	13. Was Dece If Yes, spe	edent of Hispanic ecify Cuban, Mexi	Origin? (Specifican, Puerto Ric	y Yes or No can, etc.)	- 14.	Race - Ameri Black, White,	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 🗆 Yes	2 No Spec	eify:		Sp	рөс <i>ify:</i> Whi	te
9	2 hou	ted	15. Decedent's Educa	tion	16a. De	ecedent's Usi	ual Occupation			16b. Kind	of Business/In	ndustry
215	thin 7 e.	ple	(Specify only highest grade of Elementary/Secondary (0-12)	com <i>pleted)</i> College (1-4or 5+)	lii	fe. DO NOT i	ork done during m use retired)	nost of working				
2	ed wil	Completed	12	2		Socia	al Worke				ospital	•
pu	be fit ital H d ott	Be	17. Father's Name (First, Middle, Last)					other's Name (/				
<u> </u>	d Mer narke	은	George Harrison 19a. Informant's Name/Relationship (Type	Grint	105.14	to the control	· · · · · · · · · · · · · · · · · · ·	Margare				
S	d 2 s th an th an traur		David A. Pisanic				ss (Street and Nur sy Lane,			•		b Code)
ē,	theal		20a. Method of Disposition			isposition (Na crematory or		Dat		·	tion - City or To	own, State
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Madical Examiner must be notified at once.		1 Burial 2 □ Cremation 3 □ Ren Denation 5 □ Other (Specify)	noval from State		ew Mem.		5/25/0	16	Sykos	בו ו ייי	Maryland
<u>a</u>	permit. Departminitimporta any inju		21. Signature of Funeral Service Licensee		levie		and Address of Fa	100			al Home	
Ω.	89 5 8		1200	ril		4107	Wilkens .	Avenue,	Balt	more,	Maryl	and 21229
			23a. Part1. Exter the disease, or complica shock, or heart failure. List only one	tions that caused the deal cause on each line.	th. Do not	enter the mo	^		espiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	As1>	iza	tion	Preur	Duron			1	Unk num
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of)	:						
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	nuence of):							
H	nted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury		, , , , , , , , , , , , , , , , , , , ,	•						
,	executed in and ial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):	:						
68760,	icate be executed physician and s the burial-transit	edical	L d.,									
	ntifica ng ph	Med	IF FEMALE:									
Box	death certif e attending id for use a	an/i	23b. Was decedent pregnant in the past 12 mopths?	If yes, outcome of pregnature birth 2 ☐ Feta		3 □Ectopic p	oregnancy			23d	Date of deliv Month	ery Day Year
o.	the a	by Physician/M	1 Yes 2 Who	4☐Pregnant at time of o	death	5 Other (s	specify)				MORITI	Day 19a1
	that the	Ph	Part II. Other significant conditions contri	buting to death but not res	sulting in th	ne underlying	cause given in Pa	ort I	23e. Did to	obacco use	contribute to 1	the cause of death?
EAT.	n requires that the death certif been signed by the attending should be detached for use a					, , ,	3					babiy 4 Bonknown
$\int \mathcal{T} E A$ Records,	w req	lete							24a. Was	an 2	Ah Wara aut	onsy findings available
₽~	he lav e has age 2	Completed							autor perfo	rmed?	prior to co death?	opsy findings available ompletion of cause of
PTV/C of Vital	an: T tificat tor, p	Be C	25. Was case referred to medical				26 PI	ace of Death (t		20046	1 🗆 Yes	219No
$\geq \bar{z}$	ysici iis cer direc	To B	examiner? 1 Yes 2 No	spital: 1 Thipatient 2] ER/Outpa	atient 3 D		Nursing Home			Other (Speci	fy)
	Attending Physician: r death. sector: After this certific by the funeral director.	:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Tim Inju	ne of	28c. Injury at Work?		d. Describe h			
Plesion	tendi leath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2					
P151 Division	or Atter gatter of Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm	i, street, facto	ry, office	28	City or Tox	Street and N vn, State)	lumber or Rur	al Route Number.
_	spitel ours a nerel filled	C	29a. Certifier 1 Certifying Physic	ien: To the best of my kno	owledge, d	leath occurre	d at the time, date	and place, and	d due to the	cause(s) an	d manner as a	hated
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examine one)	 On the basis of examina and manner stated. 	ation and/o	or investigatio	n, in my opinion, o	death occurred	at the time,	date and pla	ace, and due t	to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier	AAMIR			oc. License numbe			29d. Date s	igned (Month.	Day, Year)
			30. Name and address of person who com	CHÉEMA	/	MD	0006	302	5	MAY	23	2006
			30. Name and address of person who com	pleted cause of death (Itel	m 23a) (Ty	rpe, Print) 🐧	HMIR	CHCEMI	1 M.	D. / 3	5124	STONE
			SHOP CIRCLE O 31. Date filed (Month, Day, Year)	WINGS MI	LL S	MD	21	117		,		
8 3	Sta Registr		MAY 2 6 2006	WINGS MI 22. Registrar's Signary	40	arte						

		•	For State	State of Maryla		artment of H		nd Men	tal Hygien	2006	166	40
	r 1		Registrar 1. Decedent's Name (First, Middle, La	1st)		Timouto or i	<u> </u>		Date of Death		3. Time of	Death
X.	Physicia		Phyllis Maria Por							ау Үөа <i>г</i> 00 6	6:15	\mathbf{p}^M
	/Medic Examin		4a. Facility Name (If not institution, gr			4b. City, Town, or	r Location of			c. County of De		F
*	LXAIIIII		10119 Saddleridge	Drive		Myersvil	16		Fı	rederick	,	
	Funeral		5. Social Security Number 6.	Sex 7. Age (In y	rs. last birthday)				Date of Birth Month, Day, Yea	9. B	irthplace (State o.	r Foreign
193	Director		071-38-8049	1□ M 2X0 F 5	8 Yrs.	Months Days	Hours		g. 29, 1			
	D >		Usual Residence of Decedent 10a, State 10b, County	100	City, Town or Le	onation					10d. Inside Cit	ty Limits
	ehov	٦									1 🗆 Yes	•
	the M	Directo	Maryland Frederic 10e. Street and Number	k My	ersvill	e 10f. Zip Code			100.0	itizen of What C		
	with			D '						MIZON OF WHAT	ountry:	
	ne 23	Funeral	10119 Saddleridge	12. Was Decedent Ever in	U.S. 13.	21773 Was Decedent of H	ispanic Orig	in? (Specify	Yes or No-	14. Race - An	nerican Indian,	
· ^	r iten	Fun	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 1 No		If Yes, specify Cuba	an, Mexican,	Puerto Rica	n, etc.)	Black, Wh	nite, etc.	
ဗ္ဗ	urs a	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:			Specify: W	hite	
21215-0036	filed within 72 hours after deeth with the Maryland Hygiene. sther then "neture!", or iteme 23a or 28a-f ehow ent, the Madical Examinar Invaller colling at	Completed	15. Decedent's 8 (Specify only highest gi	ducation	16a. Dece	dent's Usual Occup	ation	of working	16b.	Kind of Busines	s/Industry	
2	thin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	1)	or worting				
7	ed wygier ygier yer th	ပ်		2	Platf	orm worke				nking		
Maryland	be fil bd otf	Be	17. Father's Name (First, Middle, Las	t)			18. Mother	r's Name <i>(Fir</i>	st, Middle, Maide	in Sumame)		
Z	should to	ဥ	Thomas Heasley	(Total Dist)	405-14-15			hine L		T 01-1-	7:- 0:- 4:1	
Mai	12 st h and 7 ie n traun		19a. Informant's Name/Relationship			ing Address (Street						
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heatth and Mental Hygiene. Important: if item 27 is marked other then "neturel", or iteme 23a or 28a-1 ehow any injury or other traumatic event, the Madical Expuriment matter confiled and once.	1	Richard Rahe Port 20a. Method of Disposition	erfield, husb	. 1011 b. Place of Disp	9 Saddler osition (Name of	idge I	Drive,		Location - City of		
Baltimore,	Pages nent of int: if it		1 ☐ Burial 2 X Cremation 3 (•	matory or other plac				,		
語	it. Partme	Ì	4 □Donation 5 □ Other (Spec 21. Signature of uneral Service Lic.			rg Cremato 2. Name and Addres						
Ba	permit. Departr importa any inji		1 Kusu hu F)		06 East C			-			_
	g = 5 m		23a. Part1 Enter the disease, or con	nplications that caused the d						LICK, I.	Approximate	9
	Dhusisian		shock or heart failure. List only Immediate Cause (Final								Interval Bett Onset and I	Death
	Physician /Medical		disease or condition resulting in death)	a. Renal Fai. Due to (or as a cons							2 weeks	í
7	Examiner			Multiple							4 years	ŧ
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons			.,				Jears	
	nd nd transi	Examiner	that initiated events	c								
,094	be executed sicien and burial-transit	EX	resulting in death) Last	Due to (or as a cons	sequence of):							
687	3 × 5	dicai	•	d								
9 ×	Attending Physician: The law requires that the death certificate indeath. ector: Atter this certificate has been signed by the atlending physis the funeral director, page 2 should be detached for use as the b	by Physician/Med	IF FEMALE:	23c. If yes, outcome of pre	gnancy					23d. Date of d	olivon	
Box	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ F	etal death 3	☐Ectopic pregnancy ☐ Other (specify)	,			Month Month		rear
o.	the d ry the	ıysi	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9□ Unknown								
ص	s thet	y P	Part II. Other significant conditions	contributing to death but not	resulting in the u	underlying cause giv	en in Part I.		23e. Did tobacco	use contribute	to the cause of d	eath?
of Vital Records,	w require been sig should b		Pancytpenia						1 🗆 Yes	2 ∑ No 3□F	Probably 4 Du	Jnknown
000	aw re	piet							24a. Was an	24b. Were	autopsy findings a	available
ž	ding Physician: The law h. After this certificate has funeral director, page 2	Completed							autopsy performed? 1 □ Yes 2 🖾 N	death?		1036 01
ita	ian: rtifica ctor,	Be	25. Was case referred to medical examiner?					of Death (Ch	eck only one)			
Ž	hysic his ce il dire	၉	1 ☐ Yes 2 📉 No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nur	sing Home	5 🕅 Residence	6 □Other (Sp	ecify)	
בֿ	ing P Viter t unera	ë ë	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Wor		i	Describe how inj	ury occurred		
Sio	tend death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not	ho -	45		Yes 2□N			- 11	2 12 11	
Division	or All after d Direction by	Certification:	4 Homicide determine	28e. Place of Injury - A building, etc. (Sp.	at nome, rarm, st ecify)	reet, ractory, onice			City or Town, Sta		Rural Route Numi	Der,
	• Hospitel or Attend 24 hours after death • Funerel Director: etely filled in by the		29a. Certifier 1 K Certifying P	hysician: To the best of my	knowledge dea	th occurred at the tin	ne date and	I place, and o	fue to the cause/	s) and manner :	as stated	
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edicai	(Check only 2 Medical Exe	miner: On the basis of exam and manner stated.	ination and/or in	nvestigation, in my o	pinion, death	h occurred a	the time, date a	nd place, and du	ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens			29d. D	ate signed (Mor	nth, Day, Year)	
)	d		1 land	100	-0	D	418	66	Mav	25, 200	06	
. 1	1		30. Name and address of person who			,						
	/		Kanan Hudhud, MD	, 46-B Thomas	Johnson	Drive, E	reder	ick, M	laryland	21702		
1	Sta Registi		31. Date filed (Month, Day, Year) 6	2006 32. Megistrar's Si	griature	berke						
*	2			7	-							

Please Type or Print in Black Indelible Ink

awn Parrott	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.	1664									
Physician/ ledical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	me of Death 635 hrs									
)	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2719 Hampden Avenue 4c. County of Death Baltimore										
Funeral Director	5. Social Security Number 219-70-3594 6. Sex 1 Months Days Hours Min. 219-70-3594 7. Age (In yrs last birthday) 10-25-1955 Foreign Country)	MD									
' any		Inside City Limits									
yland a-f show tonce,	MD N/A Baltimore 1 Dg. Citizen of What Country?	Yes 2 No									
vith the Maryland s 23a or 28a-f show a s notified at once, al Director											
s after death with ral", or items 23 iner must be no by Funeral											
56 n 72 hour nan "natu ical Exan											
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 permitent of Health and Mental Hygiene Important: If live it is marked other than injury or other traumatic event, the Medical	Clinton Parrott Hilda Norbeck										
MD 21 Ind 2 should alth and Me m 27 is ma aumatic ev	Jennifer Gray Daughter 2711B Hanson Avenue Apt. 2C Baltimore, MD	21209									
Baltimore, permit. Pages I an Department of Hea Important: If iten injury or other tra	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place) 20c. Location - City or Town, crematory or other place 20c. Location - City or Town, crematory or other place 20c. Location - City or Town, crematory or other place 20c. Location - City or Town, crematory or other place 20c. Location - City or Town, crematory or other place 20c. Location - City or Town, crematory or other place 20c. Location - City or Town, crematory or other place 20c. Location - City or Town, crematory or other place 20c. Location - City or Town, crematory or other place 20c. Location - City or Town, crematory or other place 20c. Location - City or Town, crematory or other place 20c. Location - City or Town, crematory or other place 20c. Locat										
Balt permit. Depart Import	21. Signature of Funeral Service icensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21	211									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Methadone Intoxication	proximate Interval tween Onset and Death									
-	Sequentially list conditions. b										
and transit	tally, leading to limited account and the control of the control o										
0, e be execute ysician and burial - trai	M UNPENDED AMENDED item#23a,27,28a-f,perME,g855,5/30/06 TT										
ox 6876 ath certificate attending phy or use as the	23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (Specify)	Year									
P.O. Bcs that the desgreed by the a detached for the by the a detached for the by Physics	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the ca	use of death?									
ords, P. w requires the as been signed should be defended by the polarization of the p	1 Yes 2 No 3 Probably 24a Was an autopsy performed? 1 Yes 2 No 3 Probably										
of Vital Records, ng Physician: The law requir Physician: The law requir when this certificate has been s meral director, page 2 should by To Re Completes		2 No									
Vital I hysician: this certification of the Control	25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other Scen	ie									
ion of tending Pheath. tor: After title funeral	28a. Date of Injury (Month, Day, Year) Fnd 5/17/2006 Fnd 4:00 FM 1 Yes 2XX No unk										
Division Hospital or Attendit 24 hours after death. Funeral Director: A stely filled in by the fi	Accident Investigation Accident Investigation Specify Specify Specify Accident Investigation Specify Spec	ute Number, City									
To the Hospital within 24 hours To the Funeral completely filled	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause.	e(s)									
To To Con		y, Year)									
	O.C.M.E. May 18, 2006 30 Name and address of person who completed cause of death (Item 23a)										
(d)	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature										
Stat Registra	MAVO COOC L										

DRIVIH 17 Rev 1/2001

		1 - For State Registrar	State	of Man		ertificate of			Reg. No.	06	16642
Physic	an	1. Decedent's Name (First, Midd	e, _{Last)} Lbbons Qua	am				2. Date of De. Month May	Day	006°	3. Time of Death 12:00 A M
/Medi Exami	cal	4a. Facility Name (If not institution				4b. City, Town, o	r Location of Death			y of Death	
Exami	iei	Pickersgill Re	-		er	Towson			Ba	1timo	re
Funeral Director		5. Social Security Number 214–40–4076	6. Sex 1 □ M 2 ☐ F	7. Age (/	n yrs. last birthday 100 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da Aug 31	y, Year)	Coui	place (State or Foreign ntry) yland
and		Usual Residence of Decedent 10a. State 10b. County		10	Oc. City, Town or I	_ocation	<u>, , , , , , , , , , , , , , , , , , , </u>				10d. Inside City Limits
Marylan -f ehow	to	Maryland Bal	timore		Tow	son					1 □ Yes 2√□ No
th the or 288 s.not	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntry?
ath wi	rai	615 Chestnut					204		US		
permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 ie marked other then "nature!', or items 23e or 28e-f ehow eny injury or other treumatic event, the Modical Examinant remained at posses.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Mai 3 ☒ Widowed 4 □ Divorce	If Yes G	Forces? 2 XNo Sive	er in U.S.	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 \ No	lispanic Origin? (Si an, Mexican, Puerti Specify:	pecify Yes or No o Rican, etc.)	Speci	ick, White,	can Indian, . etc. nite
72 ho	Completed		nt's Education est grade completed	d)	16a. Dec	edent's Usual Occup re kind of work done DO NOT use retired	pation during most of wor	king	16b. Kind of E	Business/In LMOre	dustry City
within ne. hen	mple	Elementary/Secondary (0-12)		(1-4or 5+)	1	DO NOT use retired Icher	d)		Schoo		CILY
filed y		17. Father's Name (First, Middle	Last)		168	CHEL	18. Mother's Nan	ne (First, Middle,			
id be lental ked c	To Be	Elija Francis	Gibbons				Maude 1	Estelle	Mariner		
2 should and Men ie marke eumatic	-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Ma	iling Address (Street	and Number or Ru	ral Route Numbe	er, City or Town	, State, Zip	o Code)
and 2 ealth Th 27 i		Karen Enders,	Daughter			Old West					
Pages 1 nent of H int: If ite		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from	n State		position (Name of ematory or other place		Date	20c. Location	•	
it. Pe rtmen rtant: njury		4 □ Donation 5 □ Other (21. Signature of Funeral Service	- 1			ematory I					Maryland
permit. Depertrimports ony inju		Thomas Gre	y			22. Name and Addre Crematio 299 Fred	n Society	y Of Mar	yland I	nc.	and 21228
Physician		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition	r complications that	each line.			ng, such as cardiac				Approximate Interval Between Onset and Death 2 2 CAY S
The law requires that the death cartificate be executed XIII and IIII and IIII page 2 should be deteched for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 c	0 (or as a	consequence of):	Condio	vascula	n Dise	aso		zo year S
wrequires thet the death certific been signed by the ettending p should be deteched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown		birth 2	Fetal death	B Ectopic pregnance Description Other (specify)	у			ate of delivionth	rery Day Year
requires that	þ	Part II. Other significant condit	ions contributing to	death but	not resulting in the	underlying cause giv	ven in Part I.		obacco use cor Yes 2 🗆 No	3 ☐ Prof	the cause of death?
vital neco sicien: The lawre s certificete has bee lirector, page 2 sho	Completed							24a. Was auto perfo 1 🗆 Yes	an 24b. psy prmed? 22 No	Were auto prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
VIIC icien: certifii rector,	Be	25. Was case referred to medic examiner?	Hospital:			Ott		ath (Check only o			
rthis aldit	5	1 Yes 2 No 27. Manner of Death	28a. Dat	☐ Inpatient te of Injury	28b. Time	ent 3 DOA	4 Nursing H	lome 5 ☐ Resi 28d. Describe	dence 6 ⊟Ot how injury occu		<u>(y)</u>
oding th. : Afte	tion	1 Natural 5 Pend 2 Accident inves	ing (Me	onth, Day 1		A 14 1	rk? Yes 2.▼No	fall			
To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director. After this certifice completely filled in by the funeral director, to	Certification:	3 Suicide 6 □ Could	mined 289. Pla	ce of Injury	- At home, farm,	street, factory, office		28f. Location (City or To	Street and Num wn, State) 6	15 Ch	al Rouse Number. 45 Thut AUC 21204
he Hospit in 24 hour he Funera pletely fills	Medical (29a. Certifier 1 Certify (Check only 2 Medical one)	ing Physician: To t	the best of	my knowledge, de xamination and/or	ath occurred at the ti investigation, in my o	me, date and place opinion, death occu	, and due to the	cause(s) and m	nanner as s	stated.
Ton	2	29b. Signature and title of certo	- MD	Dep	uty	29c. Licens	se number		May 2	-	
4		Philip Milit	who completed ca	6 Tx	- imble H	e, Print)	athoni.11.	QM, 9	2109		
S Regis	ate trar	31. Date filed (Month, Day, Yea		. Registrar	s Signature	parti		•			
DHMH 17 Rev 1	2001		4								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20 45 M Moses Kicheson nat 22 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard Howard Co. General Hospital Columbia If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 03 23 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. XTM 2FF Director VΆ 96 224-48-9958 Usual Residence of Decedent with the Marylend 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 27 is marked other then "naturel", or Itams 23s or 28s-f show traumstic avent, the Medical Exercitor must be notified at MD Baltimore 1X Yes 2 No NA Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 3302 Croydon Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4th grade Carpentry Self Employed na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Richardson James D. Richeson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 of Health Item 27 i 4011 Villa Nova Road, Baltimore, Md 21207 Harvey Richeson-Son 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of He
Important: If ten
any Injury or oth cemetery crematory or other place)
Timothy Baptist
Church Cemetery X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/29/06 Pleasant View, VA 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Renal dineare. End Staco **Physician** 3 munths /Medical Due to (or as a consequence of) Examiner num on to Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate has been signed by tha ettending physicien and riector, pege 2 should be deteched for use as the burial-transit UNKnown that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform 1 ☐ Yes 2. No 1 ☐ Yes 2 ☐ No : After this certifical tuneral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 XNaturat death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours eff To the Funerel DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26294

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of perso

Mis M.

31. Date filed (Month, Day, Year)

5707 culvertenst. &utonsville MD 21228

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

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MAY 2 6 2006

State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Velta D. Ranieri 2006 8:40 A M May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick MultiCare Center Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct. 8, 1909 Birthplace (State or Foreign Country) **Funeral** 1 M XXF 96 453-01-3187 Yrs. Director Texas Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Maryland N/A Baltimore Yes 2 □ No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 700 W. 40th Street 21211 USA 238 Funeral filed within 72 hours after death "naturel', or Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 XXo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXIo Specify. þ Specify: 3 X Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than eny injury or other treumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Typist/ Secretary Secretaial Work 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jefferson Davis Dick Laura Elizabeth Posey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rudolph L. Ranieri, Jr. 3811 Fenchurch Road Baltimore, MD 21218 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩Surial 2 Cremation 3 Removal from State John's Episcopal Cem. 5/27/06 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Furgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3631 Falls Road Baltimore, Maryland 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** emention /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þΛ 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 No Division of Vital 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 2 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident I Director: , 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30433 leted cause of death (Item 23a) (Type, Print) MO 21204 N CHARLES 6701 32. Registrar's Signature State 38000 Registrar

	1	For State Registrar			iai yiai	nd / Depa <i>Cei</i>		ate of l			ieiilai	Reg. I	-	Ub	16543	
Physician	_	. Decedent's Name (First, Middle	, Last)								2. Date of Month		Day	Year	3. Time of Death	
/Medical		Gerrit	L.	Ryo							May		2006		12:17 A M	_
Examiner	4	a. Facility Name (If not institution Suburban	, give street . Hospi)		4b. Ci	ty, Town, or	Location of	of Death			4c. County			
		. Social Security Number	6. Sex		no (In ure	last birthday)		thesda ler 1 Year		24 Hrs.	8. Date o	of Righ	Mont			_
Funeral Director			1 ∑ M 2		90 (<i> yrs.</i> 74	Ven	Month		Hours	Min.	(Month	h, Day, Yea	ar) 1021	Wash	nplace (State or Foreign untry) nington, DC	
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i e	1	0e. Street and Number					10f.	Zip Code				10g.	Citizen of	What Co	untry?	
by Funeral Director	3	5500 Friendshi	p Blvd	1., #2	303N			20815				Ur	nited	Sta	tes	
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Ö		7. Father's Name (First, Middle,	Last)			1	DIO	XCI	18. Mothe	er's Name	e (First, Mi	iddle, Maid			ace	-
To B	ונ	Paul Ryon							R11	th C	. Val	1/2				
1		19a. Informant's Name/Relations	hip (Type, Pr	rint)		19b. Mailir	ng Addre	ss (Street a					y or Town,	State, Z	ip Code)	-
	1	Edward Bruce/F	riend			5500	Fr	iendsl	nin B	lvd.	. #23	03N.	Chev	v Ch	ase, MD 2081	5
	2	20a. Method of Disposition				Place of Dispo	sition (A	lame of	-1		Date				Fown, State	
		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		al from State	' Mc	ntgome	ry			May 200		B.	thec	da	Maryland	
á		21. Signature - Euneral Service	Lionnee		L CI	emator 22	. Name	and Addres	s of Facilit	y Ro	bert	A. Pı	mphr	ev F	uneral Home	7
Buce		- Narite	Part 1. Enter the disease, or complications that caused the death. Do no							. 30	st Mc	ntgo:	mery	Avenue		
	1	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between	_		
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Me.		IF FEMALE:	230 161	yes, outcom	e of pream	ancu										
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vsio	200	1 □ Yes 2 □ No 9 □ Unknown		Unknown	at time of t	104(II) 5_	1 Other I	specily)								
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lete											242	Was an	24h	Were aut	topsy findings available	-
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- -	100	27. Manner of Death	288	a. Date of Inj (Month, D		28b. Time of		28c. Injury Work				ribe how in			ny)	-
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Certification:	5			Sundary, 6	(Specil	"							,			
ia.	8	25s Cartiliar 1 Certifyin (Check only 2 Medical	g Physician Examiner: O	To the bes	t of my kind	wledge death	n Denum	of at the time	ie, date an	id place.	and due to	the cause	(e) and mi	annot ac	etated. to the cause(s)	
ledicai		onej	ar	nd manner s	tated.	LIGHT ATTU/OF IN				un occurr						_
2		29b. Signature and title of certifie		11			2	9c. License				1	-		, Day, Year)	
		· · /	Lu	u_		,		D332	493			May	7 20,	2000	D	
		30. Name and address of person								CI	. 14	1		0015	6000	
		Frederick Smith	M.D.				venu	ie, Ch	ievy (unas	e, Ma	ryıar	1d 2	nø15.	-6908	
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State of Maryland / Department of Health and Mental Hygiene)

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DESIGNMOTE, INISTYISTIC Z I Z I 3-UUJO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23e or 28e-f show eny injury or other traumatic event, Ita M. Alcal Examiliars, with bus multified at		the Maryland	28e-f show	cto
	lore, maryiang z i z i 5-0036	ages 1 and 2 should be filed within 72 hours after death with	nt of Health and Mental Hygiene. : If item 27 is marked other than "naturel", or Items 23a or	or other traumatic event, the Madical Examiner must be

Physi /Med Exam

Funera

Physician /Medica Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

ian	1 - State Registrar					eath		Reg. No.				
	Decedent's Name (First, Middle,	Last)					2. Date of De Month	ath Day	Year	3. Time of Dea		
al	Medarda M. Shep						May	23	2006	2:08 a		
er	4a. Facility Name (If not institution,	give street and numb	er)		4b. City, Town, or L	ocation of Death		4c. C	ounty of Death			
	Franklin Woods				Roseda1				altimor			
	5. Social Security Number	6. Sex 7. 1 ☐ M 2√2 F	Age (In yrs. last	t birthday) _ Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da	y, Year)	Con	place (State or Fo intry)		
	216-20-1179 Usual Residence of Decedent	Λ	78	173.			Aug. 31	, 192	27 Mar	yland		
	10a. State 10b. County		10c. City, T	own or Loc	ation					10d. Inside City Li		
į	Marvland Harf	ord.	7 hri	.ngdon						1 Yes 2		
Director	Maryland Harf 10e. Street and Number	ora	ADL	nguon	10f. Zip Code			10g. Citize	n of What Cou	intry?		
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by	3 ☐ Widowed 4 反 Divorced	If Yes, Give Year or Date	s:	1	☐Yes 2∏XNo	Specify:	Specify:			ite		
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Be	17. Father's Name (First, Middle, L	ast)			1	8. Mother's Name	(First, Middle,	Maiden Si	итате)			
2	John Guzinski					Mary Ann	a Zahar	sky				
	19a. Informant's Name/Relationshi	ip (Туре, Print)		19b. Mailing	g Address (Street an	d Number or Rura	Il Route Numbe	er, City or 7	own, State, Zij	p Code)		
	Nancy Stevens	(Daughte			Parliamen			lon, N	Marylan	d 21009		
-	20a. Method of Disposition 1 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State											
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner OURS BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 242-16-7028 88 Oct 26, 1917 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Itams 23a or 28e-f ehow the Medical Examiner must be nutified at 1X Yes 2 □ No Director <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2012 McKean Avenue 21217 Funeral USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No à Specify: 3 X Widowed 4 ☐ Divorced black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk College (1-4or 5+) Elementary/Secondary (0-12) unk unk permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked ofth eny injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk unk ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bon Secours Hospital 2000 W. Baltimore Street Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 A Other (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1 shock Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** ARTERIOSCLEROTIC DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed FROKE that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical es the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetel dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificete 1 Yes 2 No 1 Yes 2 No or Attending Physician: the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10030355 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BON SECOURS 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** con First 2006 525 lou /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore ayen Wood If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex (Age In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ₹ M 2 □ F Min Yrs. unk Director 578-34-9841 76 Usual Residence of Decedent 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits in then "natural", or Iteme 23s or 28s-1 show the Medical Examiner must be notified at 1 Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 W. Franklin Street 21201 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No U.S. If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. within 72 hours after unk 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify: 3 ☐ Widowed 4 ☐ Divorced black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) unk unk permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other then 's ny injury or other traumatic event, the Magnote. Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 W. Franklin Street Baltimore, MD 21201 Ravenwood Nursing Home 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 🖾 Other (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 Rona 1 d 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosel CardioVascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 1005 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examine The law requires that the death certificate be executed the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as 980 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ld be detached for 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ bhknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate 1 Yes 2 NO 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 41 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending death. investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Thomicide To the Hospitat 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number Masem who completed cause of death (Item 23a) (Type, Print) Day, Year) 32 Registrar's Signature State Registrar

			For State Registrar	State of Maryla	-	ertificate of		1ental Hy	giene 2 (06	16649
			1. Decedent's Name (First, Middle, La	ist)				2. Date of De	eath		3. Time of Death
	Physici /Medio		Mary Jane Sa	nsone				Month ()5	23	2006	4:14 AM
0	Examir		4a. Facility Name (If not institution, give Franklin Square	4 1 1		4b. City, Town, o	or Location of Death		4c. Coun	ty of Death	ire
	Funeral Director			Sex 7. Age (In yr. 1□M 2♥F 84	s. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da NOV • 2	rth ay, Year) 3, 1921	9. Birthp Cour Mart	place (State or Foreign ntry) Ykand
	fand ow		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or I	Location				1	10d. Inside City Limits
	the Maryland 28a-f ehow notified at	ctor	Maryland Baltim	ore	Bal	'timore					1 ☐ Yes 2 🌠 No
1	with the a or 28a	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of		ntry?
5	deeth v me 23a	a la	9113 Ramblebrook		11.5		1236			.s.A.	
Mar	ours after de el', or item Examinació	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	0.5.	. Was Decedent or r If Yes, specify Cub 1 ☐ Yes 2 ☒ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecry tes or No Rican, etc.)	Spec	ace - Americ ack, White, ify: WW	
5-0	72 hc natur	etec	15. Decedent's E (Specify only highest gro	ducation ade completed)	(Giv	edent's Usual Occup e kind of work done	during most of work	ing	16b. Kind of		,
212	within 72 ene. then na	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		DO NOT use retire	d)		Balti Publi		
S P	be filed with ital Hygiene. id other ther event, the N	BeC	17. Father's Name (First, Middle, Last	;)			18. Mother's Nam	e (First, Middle			70.03
ylar	Men	ToE	Herman Rober	ts			Margar	et -	Johnson		
Mary	% g ≈ 9		19a. Informant's Name/Relationship (and Number or Run				Code)
	s 1 and if Health Item 27 other tr		Cordia Grandea 20a. Method of Disposition	(grand-daughte	Place of Dist	osition (Name of		Date	20c. Location		own. State
3altimore,	8 ~ = 5		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Control of the Contro	☐Removal from State (5)	•	ematory or other pla	,	/2006		-	laryland
ä	permit. Pag Department Important: any Injury once.		21. Signature of Funeral Service Lice				ss of Facility Sch				
	40 E # 9		Jun Jew	7			ir Rd., B			21236	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consc	ular-	tachycar	ng, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
9111	الجما	Examiner	Gequentially list currentions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):						
8760,	cate be executed ohysicien and the burial-transi	dical Exa	that initiated events resulting in death) Last	C. Due to (or as a conse	equence of):						
9	rtifical ng phy as th		IF FEMALE:								
Division of Vital Records, P.O. Box	Attending Physicien: The law requires thet the death certifix rideath. ector: After this certificate has been signed by the attending I by the funeral director, page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	☐Ectopic pregnanc	у			ate of delive	ery Day Year
S,	es thet igned b	oy PI	Part II. Other significant conditions	contributing to death but not re	esulting in the	underlying cause giv	en in Part I.	23e. Did 1	obacco use con	ntribute to th	ne cause of death?
ord	v requir been si should b	ted						174	Yes 2 □ No	3 Prob	ably 4 Unknown
II Rec	n: The law icate hes b r. page 2 st	Completed						24a. Was auto pend 1 \(\text{Yes}	an 24b. psy prmed? 200 No	death?	psy findings available mpletion of cause of 200 No
Vite Vite	ilclan certific rector	Be	25. Was case referred to medical examiner?	Hospital:	1	O#	26. Place of Death				
5	Phys or this sral di	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	■ ER/Outpatil 28b. Time	BIIL 3[] DOA	4 Norsing Ho		how injury occu		y)
ion	ittending I death. ctor: After y the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	Wo	rk? Yes 2 □No				
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not to determined	building, etc. (Spec	city)			City or To	wn, State)		l Route Number,
	ne Hosp n 24 hou se Fune setely fil	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	hysician: To the best of my ki miner: On the basis of exami and manner stated.	nowledge, dea nation and/or i	ath occurred at the time time stigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and n date and place	nanner as st , and due to	ated. the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	RL		29c. Licens	se number 4428		29d. Date sign	ed (Month, 1 23/0	Day, Year)
	8		30 Name and address of person who	1 Pipkin	9	000 Fran	Klin Squ	are Bri	ive B	ut. r	D 21237
	Sta Regist		31. Date filed (Month, Day, Year) MAY 2 6 20	32 Registrar's Sig	nature	call	V			,	
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0655A M 06 /Medical 4c. County of Deat 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 0 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min 1 M 2 F Yrs. Jan.25,1918 Maryland 212-18-3363 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location or then "naturel", or items 23a or 28a-f show It a Modical Examination at the natified at 10a. State 1 ☐ Yes 2 ☐ No Director Maryland Anne Aundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 United States 2113 Spaulding Circle Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mertial Hygiene. Important: If item 27 le marked other then "naturel", or iten any injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ 3 ☐Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4or 5+) n/a Retail years Buyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Lugenbell Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2113 Spaulding Cir. Severn, MD 21144 Charlène Smedley (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 5-27-2006 Glen Burnie, MD McCully-Polyniak Funeral Home, 130 E. Fort Ave. Baltimore, MD 21. Signature of Funeral Service Licensee J. Wayne Osterling so or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, wist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pernatremia **Physician** NPOK /Medical or as a consequence of) Examiner rena Sequentially list conditions, if any, leading to immediate cause (Disease or injury Examine been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 2 No 1 Tes 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 Tes 2 (T) No or Attending Physician: After this certification Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred linjury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: At completely filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Sig RESDOG 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) KOH HLISTOPHER 3001 S. HAWEVERST. BRITIMORE, MD 21225. 32 egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 1.10p Soist 2001 Auguste /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. (Month, Day, Year) centra Northwest Husp-tul 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 12 M 2 F Yrs. Director 81 December 08.1924 218145150 Maryland Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Iteme 23s or 28s-f ehow vinjury or other treumatic event, the Medical Examinat must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Randallstown 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 9712 Liberty Road 21133 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Ammed Forces: 1∑]Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2**X**☐ No Specify: Specify: White ð 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 **Embroidery Textile** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chaeles A. Soistman **Eleanor** Schminke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15122 Eastview Drive, Upperco, Maryland 21155
Los of Disposition (Name of 20c. Location - City or Town, Slate Charles F. Soistman Saltimore. 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State Lake View Memorial Pk 05/25/06 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityLoring Byers Funeral Directors, Inc 8728 Liberty Road, Randallstown, Maryland 21133 Twendely 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failures List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sept-c Shach /Medical Due to (or as a consequence of) **Examiner** Chemo Therenz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit etas Hic Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, oulcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. δ 2 No 3 Probably 4 Unknown Be Completed Denkrest.fr 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 22 No 24a. Was an COSS autonsy performed 1 Yes 2 No Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/OutpatienI 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No After this funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident efter death Director: 6 Could not be 3 Suicide 28e. Place of Injury - AI home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours e Le Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. vithin 2 To the ŝ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D29085 9 Ucerca ney 22 2000

Registrar

State

Court

(1)

5310

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J-

31. Date filed (Month, Day, Year) MAY 2 6 2006

			For State Registrar	ate of Marylan	d / Depart <i>Certi</i>	tment of H <i>ficate of L</i>	ealth and Death	d Mental H	/giene	006	16652
	Physici		1. Decedent's Name (First, Middle, Last) Arlene		Sills			2. Date of D Month	eath Day	Year 06	3. Time of Death 10:30 P ^M
	/Medic Examin		ta. Facility Name (If not institution, give street			lb. City, Town, or	Location of De			nty of Death	10.50 1
			Chesapeake Hospice			Linthic			Balt	imore	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 H		ay, Year)	9. Birthp Caui Wash	place (State or Foreign • D • C •
and	Mc ==		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loca	tion				1	0d. Inside City Limits
5-0036	Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23s or 28s-1 show any Injury or other traumatic event, the Medical Examinar must be notified at once.	Funeral Director	MD Prince Geo	rges N	ew Carr						¥∏Yes 2 No
with	a or	Ö	10e. Street and Number	// 1 0 0		10f, Zip Code	0737		10g. Citizen	of What Cour	ntry?
death	ms 20	era		Vas Decedent Ever in U.	S. 13. Wa			(Specify Yes or Nerto Rican, etc.)	US/	Aace - Americ	can Indian,
)36 urs after	il', or ita	by Fur	1 Never Married 2 Married 1	rmed Forces? ☐ Yes 2 ☑ No Yes, Give Year or Dates:		es, specify Cuba Yes 2√√ No	n, Mexican, Pu Specify:	erto Rican, etc.)		Black, White, cify: Blac	
Maryland 21215-0036	"nature edical E	Completed	15. Decedent's Education (Specify only highest grade con	npleted)	16a. Deceder (Give kir	nt's Usual Occupa nd of work done of NOT use retired,	ition luring most of	working		Business/In	
212 With	r than	ошо		college (1-4or 5+) 2_yrs.		ntractor			Comb	_1	
Dd.	al Hyg sotha vant,	Bec	17. Father's Name (First, Middle, Last)			METACEUT		lame (First, Middl	Capt e, Maiden Sum		
ylaı	Ment	To	Make A. Carver					ence Howa			
Mar	7 la m 7 la m traum		19a. Informant's Name/Relationship (Type, F Denise Carver /Sis	_ ′				Rural Route Num	-		
e, l	tam 2 other		20a. Method of Disposition	20b. P	lace of Dispositi	ion (Name of		Washing		on - City or To	
E Pages	nt: If I		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	val from State		tory or other place National		-20-06	Laure	1, MD.	
Baltimore,	Departm Importa any Inju		21. Signature of Funeral Service Licensee					Marshall			
00 %	707 29		23a. Pary Enter the disease, or complication	all		4217 9th	. St.]	N.W. Wash	nington	, D.C.	20011
S. C.	hysician /Medical xaminer	ı Examiner	shock, or heart failure. List only one ca Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Colon Canc Due to (or as a consequence to (or	uence of):						Interval Between Onset and Death
vision of Vital Records, P.O. Box 68760,	വര	Physician/Medical	1	yes, outcome of pregna □Live birth 2 □ Fetal □ Pregnant at time of de □ Unknown	death 3 E	ctopic pregnancy hther (specify)				Date of delive	ory Day Year
ds, I	s been signed be should be det	b	Part II. Other significant conditions contribu	ting to death but not resu	ulting in the unde	erlying cause give	n in Part I.				ably 4 Unknown
Recol	ate has beer page 2 shou	ompleted						_ perl	opsy ormed?		psy findings available inpletion of cause of
ital	is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place of D	1 ☐ Yes Death (Check only	one)	1 105	2 NO
n of V	h. After this ce funeral dire	은	1 ☐ Yes 2 ☐ No Hospi	tal: 1 Inpatient 2 Inpatient 2 (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Othe	4 Nursing	g Home 5 ☐ Res 28d. Describe	how injury occ		HOspice
	9 = 6	Certification:	2 Accident investigation	Be. Place of Injury - At ho building, etc. (Specify	ome, farm, street		′es 2□No	28f. Location City or To	(Street and Nur own, State)	mber or Rura	l Route Number,
Hospita	within 24 hours af To the Funeral D completely filled in	edicai C	29a. Certifier (Check only one) 1 Certifying Physicial 2 Medical Examiner:	n: To the best of my kno On the basis of examinat and manner stated.	wledge, death or tion and/or inves	ecurred at the tim stigation, in my op	e, date and pla inion, death o	ace, and due to the courred at the time	cause(s) and l	manner as st e, and due to	ated. the cause(s)
To the	within To the	Me	29b. Signature and title of certifier			29c. License	number		29d. Date sign	ned (Month,	Day, Year)
			Mardin O.	Welltz	щ.				05-18	3-06	
	5		30. Name and address of person who comple			Dr. M	artin T	Weltz, M.			
	Sta	10	7525 Greenway Ct. Dr	Greenbelt 32. Registrar's Signal	MD 2	2770			<i>D</i> •		
	Registr	-	31. Date filed (Month, Day, Y6ar)2006	32. Registrar's Signal	To the same of the						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician** HOWARD 2006 /Medical 4b. City, Town, or Location of Death 4c. dounty of Death 4a. Facility Name (If not institution, give street and number) Examiner ose dal Hospita Franklin Square Birthplace (State or Foreign Gountry) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 8 **Funeral** Months Days Hours 1**X** M 2□ F 78 212-30-0099 Yrs. Director MARVIAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f ahow the Medical Exactines must be notified at Essex 1 ☐ Yes 2 No Director Baltimore MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ke150 8620 21221 U-S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Maryland 21215-0036 1 ☐ Yes 💥 No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1 4or 5+) CI uck 12 rIVCR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES Kober 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a 8620 Kelso Drive Essex HNNE WIFC Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Depertment of He Important: If iter 1 Burial 2 ACremation 3 Removal from State MAY 23,06 4 ☐ Donation 5 ☐ Other (Specify) MEMATORY 21. Signature of Funeral Service Licensee 22 Name and Address of Ficility uneral Hone raul Ra 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physicien hed for use as the burial Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

P.O. I Division of Vital Records, To the Hospital or Attending Physician: The within 24 hours eliter death.
To the Funeral Director: Alier this certificate completely filled in by the tuneral director, pag ို Certification:

1 Yes 20 No

28b. Time of 28c. Injury at Work?

28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 ☐ Accident 5 Pending investigation 6 Could not be determined

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number. City or Town, State)

29a. Certifier

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of gertifier

29c. License number

29d. Date signed (Month, Day, Year)

06

State Registrar

Medical

31. Date filed (Month, Day, Year)

acura



1000 Franklin

			State of Maryland / Department of Healt State of Maryland / Department of Healt Certificate of Dea			giene 0 0	6 1665	L
	0		Decedent's Name (First, Middle, Last)		2. Date of Dea	ith	3. Time of Death	1
	Physicia /Medic		SHARON ELEANOR STOCK		MAY 25	, 2006	12:23 a	ı™
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locat	tion of Death		4c. County of	Death	
			GILCHRIST CENTER FOR HOSPICE BALTIM	MORE	0.0		IMORE	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ☒F 7. Age (In yrs. last birthday) If Under 1 Year If Ur Months Days Hou		8. Date of Birtl (Month, Day	6,1949	Birthplace (State or Forei Country) MARYLAND	ign
			Usual Residence of Decedent		DEC. I	0,1347	MARILAND	
	show	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limi	
a =0	Ba-fs	Director	MD. BALTIMORE ESSEX		-		1 ☐ Yes 2 🛣 N	
77	death with the Maryland ims 23a or 28a-f show if must be notified at		10e. Street and Number 10f. Zip Code			10g. Citizen of Wh		
48	feath	Funeral	821 CEDAR GROVE ROAD 21221 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic	ic Origin? (Spe	ocify Yes or No-	U.S. A	- American Indian,	
22	after o	Fun	Armed Forces? If Yes, specify Cuban, Mer	exican, Puerto	Rican, etc.)	Black,	, White, etc.	
Sour 2 5-0036	ours a	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	ecify:		Specify:	WHITE	
	within 72 hours after ene. than "natural", or Ite	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired)	most of worki	ing	16b. Kind of Busi	iness/Industry	
2121	withir ene. than	duic	Elementary/Secondary (0-12) College (1-4or 5+) 2 HOUSEWIFE			DOMES	STIC	
3	filed Hygi other	Be C		Mother's Name	(First, Middle,	Maiden Sumame,		
stock yland	uld be Menta Menta rrked	ToB	CLARENCE S. JONES	RITA	EURIC	Έ		
any (C)	2 sho and h is me		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and No.					
6 N	s 1 and 2 should be illed within 72 hours after death with the Maryla if Heath and Mental Hygiene. item 27 is marked other than "natural; or items 23a or 28a-f shoy other traumatic event, I'm Medical Exertinating the notified at		GEORGE E. STOCK/HUSBAND 821 CEDAR GROV 20a. Method of Disposition (Name		D, ESSE		LAND 21221 lity or Town, State	_
Sharin Stock altimore, Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, If a Meone.		WBurial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)					
₹ ±	nit. P. artme ortani injury		`4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sorvice Licensee 22. Name and Address of E					
Ba	Depa Impo any i	1	21. Signature of Funeral divice Licensee LTLLY & ZEI 700 S. CONK	LLER I KLING	NC. FU STREET	NERAL F BALTO.	HOME MD . 21224	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.				Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition Breast Cancer				Onset and Death	
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				June	
	LAdilliliei	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			· · ·		
W	ted nsit	Examiner	cause. Enter Underlying					
1/2	be executed ician and burial-transit	Exar	that initiated events c. Due to (or as a consequence of):					
8760,	ate be ex hysician the burial	dicai	d					
9	rtifica ng ph	Med	IF FEMALE:					
Вох	death certifica attending ph d for use as tl	ian/I	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy			23d. Date Month		
P.O. I	he de	Physician/Me	1 Yes 2 No 9 Unknown Unknown 1 Yes 2 Who 1 Yes 2 Unknown 1 Yes 3 Yes 3 Unknown 1 Yes 3					
	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Part I.	23e. Did to	bacco use contrib	oute to the cause of death?	
Division of Vital Records,	quires n sign uld be	ed by			1 🗆 Y	es 2 □ No 3	□ Probably 4 Dunknov	wn
000	aw requir is been si 2 should	Completed			24a. Was a	an 24b. We	ere autopsy findings availab or to completion of cause o	ole of
R	ilcian: The lav certificate has rector, page 2	Com			autop perfor 1 Yes	męd? de:	ath? ☑Yes 2☐ No	
/ita	cian: ertific ector,	Be (examiner?	Place of Death	Check only or	19)	11	-
of \	hys this al dii	To				ence 6 dother ow injury occurred		E
no	ding f h. After funer	tion	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work?		zod. Describe n	ow injury occurred	I	
İSİ	Attender deat	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office		28f. Location (S	treet and Number	or Rural Route Number,	
Ö	at or safter	Certification:	4 ☐ Homicide building, etc. (Specify)		City or Tow	n, State)		
	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier Check only (Check only and Medical Examiner: On the basis of examination and/or investigation, in my opinion,					
	the hin 24 the F	Medicai	one) and manner stated. 29b. Sonature and title of certifier 29c. License number 29c.	nber		29d Date signed /	Month, Day, Year)	
	J is C		DS8	30			25 2006	
	-1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 No.	CHAR	LES	•		
	170				D 2120			
:	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature					
	Registi	ar	MAY 2 6 2006 Stock & Specker					

		-	For State Registrar	State of	f Marylan		artmer rtifica			ind Me	ental Hy	giene Reg. No.	006	16655
de	Physicia	an	1. Decedent's Name (First, Middle,	Last)				So	mai		2. Date of De Month	Day	2000	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, Tohns Hook)	3 1	spi-tal	_	B	ait	Location o	ore	City		County of Dear	
V- S- Ad-	Funeral Director		602-21-3119	6. Sex 1⊠M 2□F	7. Age (In yrs. 30	last birthday) Yrs.	Months Months	Days	If Under: Hours	Min.	8. Date of Bi (Month, Di April 2	197	9. Bin	hplace (State or Foreign untry) ndia
	show	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo	2-0 111	10c. Cit	y, Town or L								10d. Inside City Limits 1 ☐ Yes 2 No
	or 28a-f	Irect	10e. Street and Number					rmant p Code				10g. Citiz	en of What Co	ountry?
	sath wi	eral C	13810 Lullaby		dent Ever in U	S 13	Was Dece		874	nin? (Spec	cify Yes or N		India 4. Race - Ame	ncan Indian.
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avent, I'ra Medical Examination and once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Fo	rces? 2⊠No re		If Yes, spe		Specify:	, Puerto F	cify Yes or Ni lican, etc.)		Black, Whit	
21215-0036	hin 72 ho e. an "natur Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		-4or 5+)	life.	kind of w	ork done d use retired	turina mosi	t of workin	g	Inf	ormatic	n
121	iled wil Hygien ther th		17. Father's Name (First, Middle, L	ast)		Eng	ineer		18. Mothe	r's Name	(First, Middle	1	hnology	7
Maryland	nould be if Mental I narked of	To Be	Ashok Soman			10h Maili	in - Addros	s /Street	Ap	arna	Khasn	is	Town, State,	Zin Cada)
Mai	alth and 27 is nor traum		19a. Informant's Name/Relationsh Smita Kulkarni/				-					-	aryland	
Baltimore,	Pages 1 a ent of Hei nt: If Item ry or othe		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp		State Mon	Place of Disposemetery, cre ntgome: emator:	matory`or L'V	other plac	θ)	May 2 2006	24,		esda, N	Town, State Iaryland
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service I	icensee		1108 R	2.Namea obert	nd Addres	s of Facility Pumph	rey F	uneral	L Hom	Bethe e/Cha D 2081	esda-Chevy ise, Inc.
0	Physician		23a. Part1. Error the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that conly one cause on e	aused the deal									Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to	or as a consec		1.10	1	aho	blos	h. 1	Pule	ruia	4.000
	bed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec		Lux	. 1971	· prio	3(4)	(10, 1	U(p	Jugot	19073
, 1997	e be executed sician and e burial-transit	cal Exar	that initiated events resulting in death) Last	C. Oue to ((or as a consec	quence of):								
99	# × 9	Medic	IF FEMALE:	d.										
О. Вох	at the death certifica by the attending phatached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		oirth 2 Feta nant at time of c	al death 3	□Ectopic p □ Other (s					2	3d. Date of de Month	rvery Day Year
S, D	es the	þ	Part II. Other significant condition	ns contributing to de	eath but not res	sulting in the (underlying	cause give	en in Part I			tobacco u	1	the cause of death?
Vital Record		Completed									24a. Wa auto perf 1 \(\subseteq Yes		24b. Were as prior to death?	itopsy findings available completion of cause of
Vita	icien: certific rector.	Be	25. Was case referred to medical examiner?	Hospital:				Cth	0.0		(Check only			
ō	ling Phys	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident Investig	28a. Date		28b. Time of Injury		28c. Injun Worl	4 LINU	2	8d. Describe		Other (Spe	cify)
Division	of or Attanding after death. Director: After din by the fune	ertification:	3 Suicide 6 Could r 4 Homicide determ	ned 288. Place	of Injury - At h	iome, farm, si	treet, facto	ry, office		2		(Street and own, State)		ural Route Number,
	To the Hospitel or a within 24 hours after To the Funerel Direction completely filled in the completely filled in the filled of the filled in	Medical C	29a. Certifier 11 Certifyin (Check only one) 1 Medical	g Physician: To the Examiner: On the b and man	best of my kn asis of examina ner stated.	owledge, dea ation and/or i	th occurrenvestigation	d at the tin	ne, date an pinion, dea	d place, a	nd due to the	cause(s) , date and	and manner as place, and due	s stated. to the cause(s)
	To the 1 within 2. To the 1 complet	Me	29b. Signature and title of certifier				25	9c. Licens	e number	-		29d. Date	signed (Mont	h, Day, Year)
	Λ		William	MD	an of death the	m 02-1 (T	D-:	KU	>-0	W		1009	LL, 1	2006
	HO		30. Name and address of person HS10	NO, MD, J	ohns Hop	LINS HO	Spital	1,600	North	hWall	ie Street	et, Bal	timore,	Moryland 21287
1000	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Victoria HSIAO, MD, Johns Hopkins Hagital, 600 North Wafe Street, Baltimore, Mc State Registrar 31. Date filed (Month, Day, Year) MAY 2 6 2005 22. Registrar's Signature MAY 2 6 2005													

			1_ For	State of Marylan	nd / Depa	artment of H	lealth and Me		•	16656
			Registrar		Cei	rtificate of L		Reg	No.	
	Physic	an	Decedent's Name (First, Middle, Last))			¥2	Date of Death Month	Day Year	2. Time of Death
	/Medi			ictor T	ingley		M	ay 22,	2006	1:15 P M
Ż	Examir	ner	هو. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Deatl	h
			Maryland Masonic				ysville		Baltimo	
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Ye	9. Birth	nplace (State or Foreign untry)
	Director		217-26-6942	91	Yrs.					ınada
	p y		Usual Residence of Decedent 10a, State 10b, County	10c Cit	ty, Town or La	antine.				10d, Inside City Limits
	anyla sho	_	7. 5.01							1 ☐ Yes 2 ☑ No
	8a-f	by Funeral Director	Maryland Baltime	ore	Cocke	eysville_				**
	or 2	Dire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	23e	rai	300 International	Circle		210			USA	
	e Luge	ne	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. 1	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Specif in, Mexican, Puerto Ric	y Yes or No- en, etc.)	14. Race - Amer Black, White	
36	or if	F Y	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medicul Evar in ar mast be notified at	q p	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						hite
Ϋ́	natr	Completed	15. Decedent's Edu (Specify only highest grade	cation e <i>completed)</i>	16a. Deced (Give	dent's Usual Occupa kind of work done o	ation during most of working ()	168	o. Kind of Business/I	ndustry
2	within ene. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5+))			
	filed w Hygiel other ti	S	11	n/a	Ins	spector			Insurar	ice
힏	be fill H d otl	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (F	rirst, Middle, Mai	den Sumame)	
yla	should be nd Mental s marked o umatic eve	2	Elmer	Tingley			Gertrud	e	Perkins	3
Maryland	2 sho		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street a	and Number or Rural F	loute Number, C	ity or Town, State, Z	ip Code)
	of Health item 27		Margaret L. Tingle		300	Internatio	onal Circl	e, Cocke	ysville,	MD 21030
Baltimore,			20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ R	20b. F	Place of Dispo cemetery, cren	sition (Name of matory or other place	e) Date	200	Location - City or 1	Town, State
Ĕ	Pages nent of I int: If it		'4 □Donation 5 □Other (Specify)	ioniovai nom State			05/30/2	Cook Ca	tonsville	, Maryland
ä	permit. Pages Department of Important: If if any injury or once.		21 Street Handra Burger Linguist Linguist Color of Facility							
m	Depa Impo		21. a conature Fine all saving Lidenser 22. Name and Address of Facility Lemmon Funeral Hornor Funeral Hornor Funeral Roa						iney Valle m. MD 21	9 Inc. 093
			23a. Part1. En er the di ease, or compli shock, o heart fail re. List only or	ications that cause the deat						Approximate
4			Immediate O use (Final			state G				Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in double	Due to (or as a conseq		stace a	or mac			
н	Examiner			Due to for as a conseq						
		e e	Sequentially list conditions, if any, leading to immediate any leading to immediate Cause (Disease or injury							
Pa	nsit	듩	Cause (Disease or injury							
	al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	calE								
687	phy:									
×	iding se a	W/W	IF FEMALE:	3c. If yes, outcome of pregna	ancv			1900	22d Date of deli	
Вох	atter for u	ian	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	Day Year
Ö	the d	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	eath 5	Other (specify)				
P.0	hat t		Part II. Other significant conditions con	ntributing to death but not res	ulting in the ur	ndertving cause give	on in Part I	23a Did tobaci	co use contribute to	the cause of death?
Records,	Physician: The law requires that the death certifica this certificate has been signed by the attending phraid director, page 2 should be detached for use as the	t by	his tolen comen,	110 tonsilar	-		Dulynn	1 ☐ Yes		
0	regu	Completed	, ,			10	7			
ec	sician: The law s certificate has b irector, page 2 si	du	embolism, "110	<i>サナ</i> ル				24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
=	The pag	Ç						performed 1 ☐ Yes 2 ☑		2 No
Vital	cian: ertific	Be	25. Was case referred to medical examiner?				26. Place of Death (C	heck only one)		
of \	Physi this c al dire	၉	1 □ Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Othe	4 Jursing Home	5 Residence	6 □Other (Speci	ify)
	e fe	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 28d	. Describe how i	njury occurred	
.0	Attending or death. ector: After by the funer	ati	2 Accident investigation			M 1□Y	fes 2 □ No			
Division	r Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, office	28f.	Location (Street City or Town, St	t and Number or Rur tate)	al Route Number,
	rs af	Ce								
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phys	sician: To the best of my kno ner: On the basis of examina	wledge, death	occurred at the time	e, date and place, and	due to the causi	e(s) and manner as s	stated.
	the Lin 24	Medical	one)	and manner stated.						
	To To E	2	29b. Signature and title of certifier	A		29c. License	number		Date signed (Month,	Day, Year)
	r		K.T. Jelu	to, ms.		1);	21464	3	5/2-3106	
	it		30. Name and address of per n who co	mplete cause of death (Item	1 23a) (Type, I	Print)	10/	- I		
	1		RuBert LIBert	5, MD. 350	8 Ba	nh St B	alto, or	ul 21	724	i.e.
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	122				
	Registi	rar	MAY 2 6 200	S Flerence . B	S Loo	all s				j

		1	For State Registrar	State of Maryland		tment of He ificate of D			leg. No.	006	16657
			Decedent's Name (First, Middle, Last)					2. Date of Dea	th Day	Year	3. Time of Death
	Physicia		John Alvin Th	ielemann				May 24,	2006		1:29 P M
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Death	1	4c. Co	ounty of Death	
			2521 Jerusalem Ro	ad		Joppa				rford	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	9. Birthp	lace (State or Foreign
	Director		214-24-0327 Usual Residence of Decedent	78	115.			Dec. 16	, 192	Mary	/land
	land	-	10a. State 10b. County	10c. City,	Town or Loc	ation				1	0d. Inside City Limits
	Mary fied	io,	Maryland Harford	Joppa	a					1	1 ☐ Yes 🏖 No
	28e		Maryland Harford 10e. Street and Number	ТООРД	4	10f. Zip Code			10g. Citize	n of What Cour	itry?
	3e ou		2521 Jerusalem Roa	đ		21085			USA		
	deatl	ner		Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n. Mexican, Puert	pecify Yes or No- o Rican, etc.)	14	Race - Americ Black, White,	
9	or Ite	by Funeral	Never Married 2 Married	t⊕Yes 2 □ No If Yes, Give		☐Yes 25(No	Specify:			pecify:	
21215-0036	within 72 hours after death with the Maryland ene. Then "naturel", or Items 23e or 28e-f show the Madical Expiriting must be invitited at		3 Widowed 4 Divorced	Year or Dates:	16a Danada	ent's Usual Occupa	tion		16h Kind	Wn: of Business/In	ite
5	"nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give k	ind of work done d O NOT use retired;	uring most of wor	king	TOD. TUITO	Of Dusinessani	303117
7	withi ene. then then	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Survev	or of Au	tomobile	s	Impoi	rted Car	rs
	Hygi other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan		Maiden Si	umame)	
Maryland	Mental Mental arked c	To B	Henry (nmn) Thiele	emann			Alvina	Rebecca	Bier	1	
ary	2 should and Men Is marke eumetic	11	19a. Informant's Name/Relationship (Type			Address (Street a					
	f and 2 fealth a sm 27 is		Henry B. Thielemanr			aint Joh	n's La.,	-			
ore	of He		20a. Method of Disposition 1 Burial 2 Cremation 3 Re	emoval from State	netery, crem	ition (Name of atory or other place		Date		tion - City or To	
Ë	Pag iment tent: jury c		`4 ☐ Donation 5 ☐ Other (Specify)	Hil		ervice C				on, Mar	yland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "naturel", or Items 23e or 28e-1 show any injury or other treumetic event, the Madical Examples in must be notified at ODEs.		21. Signature Funeral Service License		Mo	Name and Addres Comas Fu	neral' Ho	me, P.A.	lon 1	form 1 and	3 21 0 0 0
_	4D = 4 4		222 Boot 1 Enter the disease or comme	pations that caused the death		7 Cokesb				warytan	Approximate
			23a. Part1. Enter the disease, or compositions, or heart failure. List only on Immediate Cause (Final					,			Interval Between Onset and Death
	Physician /Medical	r i	disease or condition resulting in death)	Esophas Due to (or as a conseque		conc	NOMA				4 45ms
	Examiner			Due to (or as a conseque	siice oi).						
	-	je l	Sequentially list conditions, if any, leading to immediate cause. Ent. U denking Cause (Disease or injury	Due to (or as a conseque	ence of):						
	cuted nd ransit	Examiner	that initiated events		_						
ó,	ficate be executed physicien and is the burial-transit	E	resulting in death) Last	Due to (or as a conseque	ence of):						
68760,	ate b	dical									
	ding p	a)	IF FEMALE: 2	3c. If yes, outcome of pregnan	cv				23	d. Date of delive	erv
Вох	death certific e attending p od for use as	Physiclan/M	in the past 12 months?	1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3 🗌	Ectopic pregnancy Other (specify)				Month	Day Year
o.	0 0 0	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown							
s, P	g b b	by Pł	Part II. Other significant conditions cor	tributing to death but not resul	ting in the un	derlying cause give	en in Part I.	23e. Did t			he cause of death?
rds	quires t							10'	/es 2 X	No 3□Prot	pably 4 Unknown
Record	aw requ s been 2 shoul	plet						24a. Was		24b. Were auto	psy findings available mpletion of cause of
R	0 T 0	Completed						perfo 1 ☐ Yes	rmed? 2 No	death?	
Vital	ician: Th certificate ector, paç	Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o	ne)		
of V	S S E	7 0	1 ☐ Yes 2 XNo		R/Outpatien		4 Nursing r	lome 5 Resid			(y)
		on:	27. Manner of D th 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe	now injury	occurred	
sio	eatl or:	catl	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hor	no farm etre		Yes 2 □ No	28f. Location (Street and	Number or Rur	al Route Number,
Division	or Attence affer death Director: I in by the	Certification:	4 Homicide determined	building, etc. (Specify)		561, 140101 9, 011100		City or To			
J	To the Hospitel or Att within 24 hours affer d To the Funerel Direct completely filled in by		29a. Certifier 1 Certifying Phy	sicien: To the best of my know	vledge, death	occurred at the tin	ne, date and place	e, and due to the	cause(s) a	nd manner as s	tated.
	e Ho 124 h e Fui	Medical	(Check only 2 Medicel Exemi	ner: On the basis of examinati and manner stated.	on and/or inv	estigation, in my o	pinion, death occi	urred at the time,	date and p	place, and due t	o the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier	1.0		29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
			medouch B	CoTCW MD		D	50500		MAY	25, 2	006
	3+1			ompleted cause of death (Item	23a) (Type,	Print)	a 51 and	A.IL.		Mer. I	Day, Year) 006 and 2120
			FREDERICK B. H. 31. Date filed (Month, Day, Year)	TLER MD	10 Nor	in ornech	ie Theat	DAIDA	INE	Mary !	UNU 2120
	St Regist	ate rar	MAY 2 6 20	06	1670	S. C.					
	i legisi		111111								

			. For	State of Maryla	and / Depa	artment of H	lealth and N	lental Hyg	jiene	
			State Registrar		Cei	tificate of l	Death		eg. No U U	6 16550
	Physicia		1. Decedent's Name (First, Middle, Last) Howard	A WAL	TERS			2. Date of Dea Month	th Day Ye	
	/Medic Examin		4a. Facility Name (If not institution, give s	/ -			Location of Death	5	4c. County of D	
			3300 BENSON		210		IMORE			
	Funeral Director		5. Social Security Number 6. Sex 215 22 6059	M 2□F 7. Age (In)	7 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country) aryland
	and **		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation			,	10d. Inside City Limits
	be filed within 72 hours after death with the Maryland tal hygiene. dother than "natural", or tems 23a or 28e-f show event, the Medical Ever, it at must be netified at	tor	MD		Baltimo	~ A				1∰Yes 2□No
	or 28	Funeral Director	10e. Street and Number		X41 CAMO	10f. Zip Code			l 0g. Cîtîzen of What	t Country?
	eath v	eral	3300 Benson Avenue	# 210 2. Was Decedent Ever in	n U.S. 13.1	21227 Was Decedent of H	ispanic Origin? (So	ecify Yes or No-	USA 14. Bace - A	American Indian.
9	after d or Item	Fun	1 Never Married 2 Married	Armed Forces? 1 XYes 2 No		f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	in, Mexican, Puerto Specify:	Rican, etc.)	Black, V	Vhite, etc.
003	ural',	d by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:						white
215	within 72 ene. than "nal	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most of work	ing	16b. Kind of Busine	unk unk
212	filed with Hygiene. Ither than	Com	9 No	• .	Truc	k Driver				
and	buld be fil Mental H arked oth atic even	o Be	17. Father's Name (First, Middle, Last) Harry Herbert Walt	orc					Maiden Sumame)	
Maryland 21215-0036	in a second	ပို	19a. Informant's Name/Relationship (Type		19b. Mailir		Dorothy M and Number or Rui		Clark r, City or Town, Stai	re, Zip Code)
	1 and 2 Health a em 27 Is	14	Helen Lennox/daugh		3300	Benson Av			ore, MD	
Baltimore,	000-		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☑ Donation 5 ☐ Other (Specify)		 b. Place of Dispo cemetery, crer 	sition (Name of natory or other place		Date	20c. Location - City	or Town, State
Balt	permit. Pag Department Importent: b any injury o		21. Signatus of Fund al Service License Ronald S	ide, resto	or_ S	Name and Address tate Anat altimore,	omy Boar	d 655 W.	Baltimor	e Street
В			23a. Pan 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the decause on each line.		er the mode of dyin	g, such as cardiac		est,	Approximate Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con	UG	CANCE	12			2 YEARS
	Examiner		Sequentially list conditions, b		soquerice or,					
	ed sit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):					
Ć.	be executed sician and burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a con	sequence of):					
8760,	cate be ex physician the burial	cal	d							
9	leath certifica attending ph I for use as the	/Med	IF FEMALE:	3c. If yes, outcome of pre	egnancy				23d. Date of	dolivany
О. Вох	The law requires that the death certificate be executed tite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
<u>a</u>	res that igned b be deta	by Pl	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
Records,	w requir been si should I	eted						150		Probably 4 Unknown
I Rec		Completed	!					24a. Was a autop: perfor	sy prior	
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:		Oth	26. Place of Deat			
of	ding Phys h. After this funeral di		1 ☐ Yes 2 X No	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	it 3 DOA 28c. Injun Worl	er: 4 Nursing Ho		ence 6 Other (5 ow injury occurred	Specify)
sior	Attending er death. rector: After by the funer	catlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2 □ No			
Division		Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str ecify)	eet, factory, office		28f. Location (S City or Town		r Rural Route Number,
	to the Hospitel or within 24 hours after To the Funerel Discompletely filled in	Medical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	ician: To the best of my ler: On the basis of exan and manner stated.	knowledge, death	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and manner ate and place, and	r as stated. due to the cause(s)
	within 2 To the	Σ	29b. Signature and file of certifier	0 140		29c. License			9d. Date signed (M	•
	4)		P = CUU CO	molecular services of the services	(Itom 22-) T	Dian	6354		5 119	2006
	/		30. Name and address of person who co.	STAGNES		CATON	AVE B	ALTIMO	DRE MI	2006
	Sta 'Registi		31. Date filed (Month, Day, Year) MAY 2 6 2005	32. Registrar's S	ignature	the same	-			-

			Please Type of Print in Black Indelible ink. Ensure All		_	
			State of Maryland / Department of Health and Me		2000	16659
	3.		Trogram at	Reg. 2. Date of Death	No.	3. Time of Death
ı	Physici		Elijah JAYDEN WARD	MAU	Day Year	18:00 M
)	Medio/ Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
			Sinai Hospital Baltimore Ci	ty		
	uneral			8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign intry)
Di	rector		NONE 12(M 2∐F Yrs. World Says 110415 Yrs. Usual Residence of Decedent	mayly,	2006 MA	RYLAND
/land	Mo H		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Man	a-f sh lifted	ţō	MD BATTIMORE City			1 Yes 2 No
if T	or 28	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cou	intry?
ath w	230	rai	1209 N. WOODINGTON RD APT4 21229	eitu Van as Na	14. Race - Amer	ican Indian
ter de	item En a	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Never Married 2 Married 1 1 Yes, specify Cuban, Mexican, Puerto R	lican, etc.)	Black, White	
036	P E	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 No Specify: Year or Dates:		Specify: B	ack
d 21215-0036 filed within 72 hours after death with the Maryland Hotiene.	"naturel", or iteme 23a or 28a-f show edical Examinar r, cust be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workin	g 16t	. Kind of Business/l	ndustry
Affrin 2	hen.	d m	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)		THEONE	
d 212 filed with Hydiene	of the	ပိ	NONE NONE INFANT 17. Father's Name (First, Middle, Last) 18. Mother's Name		INFANT den Sumame)	1
ylan ould be	o pey	To Be	ELLIOTT WARD APRIL	HODG	FS	
F 45	if item 27 is marked other then "natur or other traumatic event, the Medical	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural			ip Cade)
and 2	~=		ELLIOTH WORD AND APRIL HODGES (PARENTS) 1209 N. WOOT	DINGTON	1 RD DA	ATTIMORE MD
es 1 a	f item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 (Commation 3 Removal from State)	ate 200	a Location - City or T 20 WIKENS	own, State 2122
Baltimore,	Important: If item 2 eny injury or other once.		4 Donation (5 Utiler Ispecify)	000 Bo	Manager M	anyland 21229
Ball Sermit	Impor eny in		21/ Signature of Furiest Service Licentee 22. Name and Address of Facility 36.26		PEBIG SUB	ove wandlang
			As Part Enter the issesse, or semplications that caused the death. Do not enter the mode of dying, such as cardiac or			Approximate
			skr ck, or heart failure. List only one cause on each line.			Interval Between Onset and Death
	sician edical		Immediate Cause (Final divase or condition resulting in death) a. SEVERE IMMATURITY Due to (or as a consequence of):	2		
Exa	miner					
/ n	=	ner	Sequentially list conditions, if any, teating to instructions cause. Enter Underlying			
ecute	and trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):			
60, be executed	ysician and le burial-transit	cai E	Due to (or as a consequence of):			
O	attending physi for use as the b		d.			
I Records, P.O. Box 68' The law requires that the death certificat	nding use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deliv	/ery
de ag	e atte	icia	250. Was decembed pregnant 1 Live birth 2 Fetel death 3 Ectopic pregnancy 1 Yes 2 No 9 Unknown 5 Other (specify)		Month	Day Year
P.O.	detached	hys	9 Li Unknown		1	
8 t	5 6	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to 2 Mo 3 ☐ Pro	the cause of death?
Ord	peen si	Completed			Δ	
Se law	SC	mpi		24a. Was an autopsy performer	prior to o death?	opsy findings available ompletion of cause of
<u>a</u>	certificate rector, pag		25. Was case referred to medical 26. Place of Death	1 □ Yes 2		200
Vision of Vital	s cert	o Be	examiner?		e 6 ☐Other (Spec	ifv)
o f	After this funeral di	ı.	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	8d. Describe how		,,
SiOr andin	or: Aff	atio	2 Accident investigation M 1 Yes 2 No			
	Director: in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Stree City or Town, S	t and Number or Rui itate)	ral Route Number,
Dital o	iled i		20. Continue Charitaine Charitaine To the heat of my keepledge death convered at the time date and class a	and due to the save	a/a) and manage as	atatod
To the Hospital or	To the Funeral Director. After this certificate his completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	ed at the time, date	and place, and due	to the cause(s)
o the	o the	₹ S	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month	, Day, Year)
) [0		Jas El Buen L RES-000		5/16/00	٥
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	7 11		,
	1		Sinou Hospital of Bultmore 2401 W. Belvedore Are, I	Saltimore	, MDZ	1215
- 2	Sta Regist	ate	31. Date filed (Month, Day, Year) MAY 2 6 2006 Registrar's Signature			
	uedia	rai	THE TOTAL PROPERTY OF THE PARTY			

		1 - For State Registrar Amend ITEM		-	-	irtment of He tifioate of E		nd Mental Hy	/giene Reg. No.	006	16660
Physici		1. Decedent's Name (First, Middle, Las Margaret F. Willi	st)					2. Date of D Month May 24	Day	Year	3. Time of Death 6:00 PM M
/Medio Examir		4a. Facility Name (If not institution, give Gilchrist Center	street and number)	e Car	re	4b. City, Town, or I	Location of I	<u>-</u>	4c. Co	unty of Deat	
Funeral Director		5. Social Security Number 6. S 213-12-8935 1	ex 7. Age	e (In yrs. la 83	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of B (Month, D 10/26)		9. Birt	hplace (State or Foreign buntry)
ס		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation					10d. Inside City Limits
e Mary 8a-f sho	ctor	MD Anne Ar	undel	Hand	over						1 Yes 2 No
with th	Dire	10e. Street and Number 1494 Gesna Drive				10f. Zip Code 21076				of What Co ed Stat	-
s after death , or Itams 23	by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give			Vas Decedent of His Yes, specify Cuban	spanic Origir n, Mexican, F Specify:	n? (Specify Yes or N Puerto Rican, etc.)		Race - Ame Black, White Becify: Whi	e, etc.
perillinities in Mary failure 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or itams 23e or 28e-1 show any injury or other traumatic avant, if a Medical Examiliar in united at once.	Completed b	3 Widowed 4 □ Divorced 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	Year or Dates: ducation de completed) College (1-4or 5	+)	(Give I life. D	ent's Usual Occupat kind of work done do OO NOT use retired)	uring most o	of working		of Business/	
d be filed with the filed with the filed with the filed with the cavant, the cavant, the files with the cavant, the files with	Be Cor	12 17. Father's Name (First, Middle, Last) Meril Ridgely			Cashi		18. Mother's	s Name (First, Middle ine Slaugh		mame)	
d 2 should d 2 should th and Mer 17 Is marke traumatic	To.	19a. Informant's Name/Relationship (Mrs. Fran Jones/Da				•	nd Number	or Rural Route Numi	ber, City or To		Zip Code)
Pages 1 and ent of Health nt: If item 2: ry or other 1		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification)		Cei	ace of Dispos metery, crem	sition (Name of natory or other place)	Date May 27 2006	20c. Locat	ion - City or	Town, State Maryland
Dallillor permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licer		8900				eral Alternes Drive I			ryland
Physician /Medical Examiner	er	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Secuentially list conditions if any, leading to immediate cause. Enter Underlying	a	a conseque	ence of):	1		ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
box bot buy, death certificate be executed e attending physician and id for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):						
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal	death 3 🗌	Ectopic pregnancy Other (specify)			23d	Date of deli Month	ivery Day Year
w requires that the been signed by the should be detached	þ	Part II. Other significant conditions of	ontributing to death b	ut not resul	lting in the un	nderlying cause give	n in Part I.		tobacco use Yes 2 ☑ 1		the cause of death?
The lay ate has page 2	Completed							perl	s an 2 opsy ormed? 2 No	4b. Were au prior to death?	stopsy findings available completion of cause of
Or VIIal IN Physician: The trinis certificate harral director, page	o Be (25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatie		R/Outpatien			f Death <i>(Check only</i> ing Home 5 ☐ Res	-	Salvan (Com	HIRONE
Jn Ol	 -	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Day	ry :	28b. Time of Injury	28c. Injury Work		28d. Describe			sny) 7703; 700
LIVIS tal or Atta rs after de al Diracto ed in by th	Certification:	3 Suicide 6 Could not be determined				eet, factory, office			(Street and Nown, State)	lumber or Ru	iral Route Number,
To the Hospital or Attant within 24 hours after death To the Funaral Director: completely filled in by the	edicai	(Check only 2 Medical Exar	ysician: To the best niner: On the basis of and manner sta	examinati		restigation, in my op	inion, death		, date and pla	ace, and due	to the cause(s)
With	Σ	29b. Signature and title of confider	my Re	J'	mo	29c. License	500	ARLES STR	M A	7 2	1, Day, Year)
6		30. Name and address of person who	iley			70 WS	ON, 1	MD ZIZ	04		
St Regist	ate rar	MAY 2 6 200	6 Assert	ar's Signati	ure						

Amedn item#5, perFH, C858, 5/26/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** LENA IDA WARD MAY 2006 4:04PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 5122 E. Joppa Rd. Perry Hall 8. Date of Birth (Month Day Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Hours Maryland 1 M 2/C/F 89 Director Usuat Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Menial Hygiene. Important: If Item 27 ie marked other then "natural", or Iteme 23a or 28a-f show eny injury or other traumatic event. If a Modical Examinar must be notified at Perry Hall - Baltimore County 1 Yes XXNo Baltimore Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21128 USA 5122 E. Joppa Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 🌂 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: by If Yes, Give Year or Dates: 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sales Person Retail 7 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oliver F. Baseman Ida Scharf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Pennewill (Daughter) 5122 E. Joppa Rd. Perry Hall, Md. 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 5-20-2006 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ใกล้รริลักก์ ครั้งก็ครั้งไม่ Home 7401 Belair Rd. Baltimore, Md. 21236 Pint. Enler the discusse, if complication it at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, such, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician egase /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attanding physicien and the dor use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) datached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 **N**No peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? certificate 1 Yes 2. No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ۵ 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No efter death 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral I 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and two of certifier 29c. License number 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 4920 31. Date filed (Month 32. Registrar's Signature State 6 2006 Registrar

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H		ental Hygie Reg.	ZHUh	16662
			1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Charles Brice Woo	odbc			N		006	8:43 P ^M
	Examin		4a. Facility Name (If not institution, given	e street and number)		4b. City, Town, or	Location of Death		4c. County of Death	ו
			Frederick Memoria			Frederic			rederick	
	Funeral			Sex 7.Ag 1⊠M 2□F	e (In yrs. last birthday,	If Under 1 Year Months Days	Hours Min.	 Date of Birth (Month, Day, Ye 	ar) Coi	nplace (State or Foreign untry)
	Director		230-44-3778 Usual Residence of Decedent		71 Yrs.		F	'eb. 20,	1935 Virg	inia
	and and		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	denyl feho	0	Maryland Frederi	a le	Erodondalı					1∭Yes 2□No
	the 1	Director	10e. Street and Number	SK.	Frederick	10f. Zip Code		10g.	Citizen of What Co	untry?
	with weigh	<u> </u>	505 Fairview Ave			21701				,
	me 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	21701 Was Decedent of H	ispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No-	14. Race - Amer	
(O	r He	표	1 ☐ Never Married 2 X Married	Armed Forces? 1 X Yes 2 1 If Yes, Give	No			tican, etc.)	Black, White	e, etc.
5-0036	172 hours after death with the Maryland "naturel", or fleme 23e or 28e-f ehow officel Extractional be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1955-59	1 ☐ Yes 2 🔀 No	Specify:		Specify: Whi	te
2-0	72 hc	Completed	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual Occupa	ation during most of workin	166	. Kind of Business/l	ndustry
2121	within ene. then "	ng u	Elementary/Secondary (0-12)	College (1-4or 5	life	DO NOT use retired	1)	9		
7	filed wi Hygien Sther th	S		1	Manag	ement/Adm	inistratio		surance C	ompany
Maryland	2 should be filed withir and Mental Hygiene. Ie marked other then aumatic event, the M	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid	den Sumame)	
yla	should be nd Mental marked o	ဥ	William David Woo				Irene Mars			
Jar	2 sh and le m		19a. Informant's Name/Relationship				and Number or Rural			,
	permit. Pages 1 and 2 should be filed within 72 hr Department of Heelih and Mental Hygiene. Importent: If Item 27 Ie marked other then "nature any injury or other traumatic event, the Medical Once.		Kathleen Wood, w	Lfe			Avenue, Fr			
0	ges 1 t of H if ite		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 [Removal from State	20b. Place of Disp cemetery, cre	matory or other place		200	. Location - City or	Iown, State
Ë	tent:		4 □ Donation 5 □ Other (Speci	(y)	Smithsbu	rg Cremat	ory May 22	2, 2006 S	mithsburg	, Maryland
Baltimore,	Departition of the policy of t		21. Signature of Funeral Service Lice	nsee	2	Name and Addres	ss of Facility Keen	ey and B	asford Fu	neral Home
	20 = e d		Kyan M D	Uger			hurch Stre			
			23a. Part1. Enter the disease, or conshock, if he art failure. List only	o le couse on each li	I the death. Do not en ne.	ter the mode of dyin	g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Tumor	lysis synd:	rome			1	4 davs
1	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
4	- Adminier	L.	Esquentially list conditions,		le Organ S	ystem Fail	lure			4 days
	p #s	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):					
	and and -tran	кап	that initiated events resulting in death) Last		ancy - Prima consequence of):	nar unkno	own			2 weeks
8760,	The law requires thet the deeth certificate be executed sie hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	E E		545 (5) 43	a consequence on.					
87	physicate physicate	Physician/Medical		d					1	
9 X	eeth certific ettending p for use as 1	Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				22d Date of dall	
Box	etten for u	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of deli Month	very Day Year
o	that the de ed by the detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	time of death 3					
P.0	thet the		Part II. Other significant conditions	contributing to death b	ut not resulting in the	anderlying cause give	en in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ds	uires l signe	d by	h/o prostate car	cinoma				1 ☐ Yes	2 X No 3 □ Pro	bably 4 Dunknown
Š	w requir been si should	Completed						24a. Was an	24h Were au	topsy findings available
Re	ne lar s hes ge 2	Ę.						autopsy	prior to c	completion of cause of
a	ficete or, pa	ပိ	25. Was case referred to medical					1⊠Yes 2□	No 1 Yes	2 ∑ No
of Vital Records,	ding Physician: The lav h. After this certificete hes funeral director, page 2	00	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outpatie	ot all post Othe	er: 4 D Number 14 am			
of	Phy rthis	 7	27. Manner of Death	28a. Date of Inju (Month, Da		III JU DOA	4 Nursing Hom	8d. Describe how i	e 6 □Other (Spec	ery)
on	th. Afte	ţ	1 Natural 5 Pending 2 Accident investigation		y Year) Injury		k? Yes 2 □No		, , , , , , , , , , , , , , , , , , , ,	
Division	Attending r death. ector: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not I	28e. Place of Inj	ury - At home, farm, si	reet, factory, office	2		t and Number or Ru	ral Route Number.
Ē	offer Oliver din D	ert	4 Homicide	building, et	c. (Specify)			City or Town, S	tate)	
	the Hospital hin 24 hours the Funerel hpletely filled		29a. Certifier 1 X Certifying P	hysician: To the best	of my knowledge, dea	th occurred at the tin	ne, date and place, a	nd due to the cause	e(s) and manner as	stated.
	P Ho 124 h	edical	(Check only 2 Medical Exa	miner: On the basis o and manner st	f examination and/or it ated.	nvestigation, in my o	pinion, death occurre	d at the time, date	and place, and due	to the cause(s)
	To the Hospital or Attent within 24 hours efter deatl To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier			29c. Licens	e number	29d.	Date signed (Month	, Day, Year)
	6	1			Nug	D14626		Moss	20, 2006	
1	2	1	30. Name and address of person who					ridy	20, 2000	
	D		P. Gregory Rausch	. MD. 501	West Sever	ith Street	. Frederi	ck. Marvl	land 2170	11
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature					
	Regist	rar	MAY 2 6 2	006 Jan	w St Sty	entil .				

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		•	1 - For State Registrar	State	e of Mai	ryland			nt of H <i>te of L</i>		and M	ental Hy	giene Reg. No.	_ U \	16	166	563
			Decedent's Name (First, Middle	, Last)								2. Date of De	ath			3. Time ol	Death
	Physici /Medic		John Michael Zu	si							1	Month Aay 21,	Day 200		Year	11:30	A M
	Examin		4a. Facility Name (If not institution,	, give street and	d number)			4b. City	, Town, or	Location o				County	of Death		
			2609 Mill Race						lericl	-			Fr	eder			
	Funeral Director		5. Social Security Number 096-30-8929	6. Sex 1 X M 2□	, -	(In yrs. Ias 64	st birthday) Yrs.	If Under	or 1 Year Days	If Under 2 Hours	Min.	8. Date of Bin (Month, Da Nov 11	th 19, Year) 19	41	9. Birthr Cour New	place (State on ntry) V York	or Foreign
	pu ,		Usual Residence of Decedent 10a. State 10b. County			10a Cib	Taura and a									104 1-14-0	15 . 1 2 - 15 -
	anyla •hov	5	,				Town or Lo	cation								10d. Inside Ci 1 □ Yes	2X No
	he M	Director	Maryland Freder 10e. Street and Number	ick		Frede	rick	104.7	ip Code				10g. Citi		/hat Cau		
	with sor			D . 1										2011 OF W	mat Cour	ntry :	
	na 23	era	2609 Mill Race		Decedent Ev	er in U.S.	13 \	217		spanic Orio	nin? (Spe	cify Yes or No	USA	14. Race	- Americ	can Indian,	
36	be filed within 72 hours after deeth with the Maryland Hyglene. d other than "natural", or items 23a or 28a-f ehow do other than "natural", or items 23a or 28a-f ehow event, the Madical Examinar must be notified at	by Funeral	1 ☐ Never Married 2 🕅 Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 X Y	ed Forces? /es 2 No s, Give or Dates:	400	4- "	f Yes, sp	ecify Cuba 2 X No	n, Mexican Specify:	, Puerto F	Rican, etc.)			k, White,	etc.	
21215-0036	tura eal E	ed	15. Decedent		U Dates.		16a. Deced	dent's Us	ual Occupa	ıtion			16b. Ki	nd of Bu			
Ç	within 72 ene. then "net he Madic	Completed	(Specify only highes	t grade comple			(Give	kind of w	rork done d use retired,	uring most	of workin	ig .	100.10	110 01 00	31110337111	GUSTRY	
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<u>a</u>	should be filed with nd Mental Hygiene marked other the imatic event, Ine I	20	Albert	James			Zusi			Jun	e 			Há	arth		
2	s 1 and 2 should if Health and Mer Item 27 is marke other treumatic		19a. Informant's Name/Relationsh Pamela Zusi, Wi)			-				Route Number Frederi				,	1
Baltimore,	s 1 av		20a. Method of Disposition	_		20b. Plac	ce of Disponetery, cren	sition (Na	ame of	a)	D	ate	20c. Lo	cation - (City or To	own, State	
Ë	permit. Pages Department of H Important: If Ite any Injury or of once.		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation, 5 ☐ Other (Sp			1	John'				av 2.	5, 2006	Fred	eric	k. M	arvlan	ıd
a	mit. partm ports y Inju		21. Signature Fur eral Service L	icense								ney and					
n	88 18 8		Kellyn	Kokou	ン M	00706	10	6 Ea	st Ch	nurch	Stre	et, Fr	eder	ick,	MD	21701	
ı			23a. Part1. Enter the disease, or shock, or heart failure. List	complications to	hat caused the	he death.	Do not ente	er the mo	de ol dying	g, such as	cardiac or	respiratory ai	rrest,			Approximate Interval Bet	e ween
	Physician		23a. Part 1. Enter the diffease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Recurrent Esophageal Carcinoma													Onset and I	Death
Н	/Medical Examiner		resulting in death)		e to (or as a											J HIOLIC	
	Examine	_	Sequentially list conditions,	b	THE PERSON IN	more service						 					
	ed isit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du	e lu (ui as a	conseque	nce of).										
	icate be executed physicien and s the burial-transit	Examine	that initiated events resulting in death) Last	c. Du	e to (or as a	conseque	nce of):	_							-		
09/8	sicier buria	dicai E															
	ficate p phy: is the	edic		0.	-												
ROX	death certifi e attending p id for use as	Z/W	IF FEMALE: 23b. Was decedent pregnant		, outcome of								2	23d. Date	of delive	ery	
ň	death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ P	ive birth 2 regnant at ti			Ectopic Other (s	pregnancy pecify)					Mon		-	Year
J.	at the de by the a tached	hys	9 Unknown	1	Jnknown												
Vital Records, I	The law requires thet ite hes been signed b age 2 should be deta	þ	Part II. Other significant conditional Tracheostomy	ns contributing	to death but	not resulti	ing in the ur	nderlying	cause give	n in Part I.			obacco u Yes 2¶			necause of d oably 4 ⊟U	
 ပ်	w requires been si should t	lete										24a. Was	an	24b. W	/ere auto	psy findings a	available
		Completed											rmed? 2][[] No	pr de	rior to cor eath? Yes	mpletion of ca	ause of
<u>ra</u>	len: artifica ctor, j	Be C	25. Was case referred to medical examiner?	-1						26. Place	of Death	(Check only o					
o	hysic his ce I dire	10	1 ☐ Yes 2 X No	Hospital:	1 🗌 Inpatient	2 □ EF	NOutpatien	3 🗆 🗅	Othe	^{IC} 4□Nur	rsing Hom	ıe 5⊠ Resid	dence 6	5 □Othe	r (Specif	y)	
Ç Ç	ding Ph h. After th funeral	on:	27. Manner of Death 1 X Natural 5 ☐ Pending		Date of Injury Month, Day	Year) 2	8b. Time of Injury		28c. Injury Work			8d. Describe h	now injury	y occurre	d		
<u> </u>	tendi death tor: A the fi	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation of be				М		′es 2□N							
Division	pital or At burs after o teral Direct filled in by	Certification:	4 Homicide determi	ned 208. F	Place of Injunguilding, etc.	y - At hom (Specity)	e, larm, stre	et, lacto	ry, office		2	8I. Location (5 City or Tox			r or Rura	I Route Numi	ber,
	To the Hospital or Attending Physiclen: within 24 hours alter death: to the Funeral Director: After this certific completely filled in by the funeral director;	Medical	29a. Certifier 1 Certifying (Check only one)	g Physician: To Examiner: On t and	o the best of ne basis or e manner state	xaminatio	edge, death n and/or inv	occurre estigatio	d at the tim n, in my op	e, date and inion, deat	d place, a h occurre	nd due to the d	cause(s) date and	and man place, a	ner as st nd due to	ated. the cause(s	:)
	omple	Me	29b. Signature and title of certifier	3				25	Oc. License	number			29d. Date	e signed	(Month,	Day, Year)	
}	7		*CPI		Z	6	9		D 1 46	526			Mav	22,	200)6	
	1		30. Name and addre	who completed	cause of dea	ath (Item 2	3a) (Type, l	Print)					,	,			
1			P. Gregory Ra					ever	nth St	treet	, Fre	ederick	, Ma	ryla	and 2	21701	
	Sta Registr		31. Date filed (Month, Day Year)	6 2006	32. Registrar	's Signatur	A A	254	م								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 18, EDITH AMOS 2006 ELEANOR May 3:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Air Bel Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 5/26/1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 X F Days Hours 82 Director 212-22-1804 Maryland Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Iriside City Limits 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Harford MD. Forest Hill 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö 1127 Sharon Acres Road 21050 or Itema 23a United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after of Hygiene.
Hygiene.
ther than "natural", or Item 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify þ 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed will Depertment of Health and Mental Hygiene Important: If Item 27 ie marked other that any filory or other traumatic event, that 900g. 12 Hairdresser Cosmetology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilbur Johnson Grace Quickley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21040 19a. Informant's Name/Relationship (Type, Print) Leonard R. Johnson/Son 1913 South Ridge Drive Edgewood, Nd. 20a. Method of Disposition
1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery 5/24/06 White Hall, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician wingrang disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last M0000052078 Due to for as a sursequence off Examiner burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ZENo 2 this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after d 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as slated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 18/2006 DOO 63770 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEORGE ISCKARW MMC 500 MPER CHESAPEAKE DR. BELAIR

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 2 5 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrat Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician May 10, 2006 5:16A. Elizabeth A. Boone /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Frederick Frederick 1710 Carriage Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2**X**F Yrs. November 21, 1948 57 Maryland Director 216-82-2012 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 □ No Directo **Maryland** Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 21702 U.S.A. 1710 Carriage Court death Funeral Items : 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: filed within 72 hours atter 1 Never Married 2 Kowarried Baltimore, Maryland 21215-0036 5 white 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home nd 2 should be filed lith and Mental Hygid 27 ie marked other r treumatic event, it 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 ie marked any jury or other treumatic evones. William Beaver Mildred Pattison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1710 Carriage Court, Frederick, Maryland James Boone - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory 5/11/2006 Frederick, Maryland 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 Rarow Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EXECUSIVE **Physician** /Medical Due to (or as a consequence of): Examiner (7 Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician and tor use as the burial-transit The law requires that the death certiticate be executed Due to (or as a consequence of) Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death signed by the at d be detached to 5 Other (specify) o 9 Unknown 9 Ulnknown Records. P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 A No certificate 2□ No 1 Tyes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes 2 this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: To the Hospital or Attending Division 1 Natural 5 Pending atter death.

Director: Aff 1 ☐ Yes 2 ☐ No 2 ☐ Accids it 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a To the Funeral D completely tilled in 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie D14626 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 L010306 32. Register's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

	•	Pleas 1 - State Registrar	Se Type or F State of		nd / D	epa	lelible In rtment of tificate of	Health	and M	_		ne2 ()	E	16666
4		Decedent's Name (First, Middle,	Last)							2. Date of D	eath			3. Time of Death
Physicia		Dorothy F. Boyk	in							May 10	0, 2	2006	Year	1:05 PM
/Medic	_	4a. Facility Name (If not institution,		ber)			4b. City, Town	, or Location	of Death			4c. County	of Death	-
Examin	eı	Maplewood Park	-	,			Bethes	da			N	lontg	omery	У
Euraval		*	6. Sex	7. Age (In yr	s. last birth	iday)	If Under 1 Ye		r 24 Hrs.	8. Date of B	irth		9. Birth	place (State or Foreign
Funeral Director		508-09-9465	1□ M 2Д F		85 Y	rs.	Months Da	s Hours	Min.	Oct 2	ву, Уе. 8 • .	[920	Nebi	raska
		Usual Residence of Decedent												
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Mar Mar	to	Maryland Montgo	mery	Bet	hesda	a.								1 ☐ Yes 2 🖺 No
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3a o	Funeral Director	9707 Old George	town Road	#119			20814				USA	A		
death	Jer	11. Marital Status	12. Was Dece	dent Ever in	U.S.	13. W	/as Decedent of Yes, specify C	of Hispanic O	rigin? (Sp	ecify Yes or N	lo-			ican Indian,
after or its		1 Never Married 2 Marrie	Armed For	2 📉 No			Tes, specify C			nican, etc.)			ck, White	
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t so the item		20a. Method of Disposition			Place of cemetery	Dispos	ition (Name of atory or other	olace)	May 1	PB,	20c.	Location	City or T	own, State
Page ient c nt: # ry or		1 ☐ Burial 2 🕅 Cremation 4 ☐ Donation 5 ☐ Other (Sp		Ch	-		e Crema		200	6	Be:	ltsvi	11e,	Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "natural; or itame 23s or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service L	icensee //			C22.	Name and Ad	dress of Faci	iğ t i o	n Serv	ice	Ρ.0	. Bo	× 784
Depa impo eny ii		1 Bavel I	Heltte		0125									e, MD 21029
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that sed b deta	by Physician/Medica	Part II. Other significant condition	ns contributing to de	ath but not re	esulting in	the un	derlying cause	given in Part	1.	23e. Did	tobacc	o use con	tribute to	the cause of death?
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The law ate has b page 2 st	E D									auto	opsy formed		prior to co death?	empletion of cause of
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thin the myple	Mec	29b. Signature and title of certifier		- Jaiou.			29c. Lic	ense number			29d.	Date signe	d (Month.	Day, Year)
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1		30. Name and address of person v		1		-								

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

MAY 1 5 2006

32. Hegistrar's Signature

			For State Registrar	State of M	aryland / I		artment of H tificate of L			eg. No.) 6	16667
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	/Medic Examin		4a. Facility Name (If not institution, give	street and number,			4b. City, Town, or		of Death	4c. County		
			Bradford Oaks 1 5. Social Security Number 6		: Renab ge (In yrs. last bi	irthday)	Clinto	n If Under:	24 Hrs. 8. Date of Birth			George
	Funeral Director			_M 21XF 8		Yrs.	Months Days	Hours	Min. (Month, Day	, Year)		plece (State or Foreign intry)
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Lo	cation					10d. Inside City Limits
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Maryland	is ma		19a. Informant's Name/Relationship		_		•		or or Rural Route Numbe • Ft. Wasl	-		
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ē	Pages nent of int: if its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specific) _		natory or other place cremator:		05/12/2006	Edgewa	ater	MD.
Baltimore,	permit. Pages 1 and Department of Health important: if item 27 any injury or other tr		21. Signatur of Funeral Service Licer	H	,				Geo. Kala 11 Rd. Oxo	as Fune	eral	Home
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4	res that the igned by th be detache	by Pr	Part II. Other significant conditions of	ontributing to death	but not resulting	in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contr	ibute to	the cause of death?
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Division	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer.	Certification;	3 Suicide 6 Could not b 4 Homicide determined	286. Place of Ir	njury - At home, f etc. (Specify)	farm, st	reet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	er or Rui	ral Route Number,
	ne Hospit n 24 hour ne Funere	edical (of examination a				d place, and due to the o th occurred at the time, o			
	To the To the comp	ž	29b. Signature and title of certifier				29c. License	number	2	29d. Date signed	(Month,	Day, Year)
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12	(10)		30. Name and address of person who William 1. IANN 31. Date filed (Month, Day, Year)	completed cause of	(1701 Co	oiw	the Rose	f 'te	+ washing	יישות היי	1 hm	<u> </u>
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State of Maryland / Department of Health and Mental Hygien	e2	0	0	6

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			1 - For State Registrar		Ce	rtificate of	Death		Reg. No.	UU	10000
			1. Decedent's Name (First, Middle, La.	st)				2. Date of De	ath		3. Time of Death
	Physici /Medio		Helen Dodd Bru	ner				Month May	6, 200	Yeer 16	5:33 P ^M
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of Death		4c. County		1 - 3 - 3
			Holy Cross Hospi	tal		Silver	Spring		Mo	ntgom	nerv
	Funeral		5. Social Security Number 6. S			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th		lace (State or Foreign
	Director		304-20-6870 Usual Residence of Decedent	82	Yrs.			April 2	9, 1924	Turl	key
	and w		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				1	0d. Inside City Limits
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	28a	Je.	Maryland Montgom 10e. Street and Number	iery s.	ilver S	10f. Zip Code			10g. Citizen of	What Coun	ntry?
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	deati	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	- 14. Rad	ce - Americ	
9	or its	正	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No		1 ☐ Yes 2 ☑ No		nican, etc.)		ck, White,	
g	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow ta Medical Examinat must be notified at	d b	3 ₩idowed 4 Divorced	Year or Dates:					Specif	y:Whit	.e
Ϋ́	nat allca	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ring	16b. Kind of B	lusiness/ind	dustry
2	withir ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+) 4		kkeeper	u)		Bi		
0 0	filed Hygi ther ant, I		17. Father's Name (First, Middle, Last)		DOC	kkeeper	18. Mother's Nam	e (First, Middle	Finance . <i>Maide</i> n Sumar		
Maryland 21215-0036	id be ental ked c	To Be	Wilson F. Dodd					Benedi		,	
37	shou nd M mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rur			, State, Zip	Code)
ž	od 2 elth a 27 is		Amy E. Moore/ Dau	ghter	5813	Maple T	errace, L	aurel,	Marylan	d 207	07
e,	It and the second		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Location	- City or To	wn, State
Ĕ	Page Int.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemovai from State	-	n Cremato	′ Mav	10, 06	Alexand	ria.	Virginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than *natural; or items 23s or 28s-f show among injuly or other traumatic avant, its Medical Examinat must be notified at anote.		21. Signature of Funeral Service Licer	nsee	F22	Name and Addre	ess of Facility	Funeral			
_	807 2 9		J-Ken Sale		50	00 Univer	sity Blvd	, W, Si	lver Sp	ring,	MD 20901
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dear one cause on each line.	th. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Sepsis							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):						
	Zxammer	_	Sequentially list conditions,	b. Cellulitis,	Right	Leg					
	ted nsit	nine	cause (Disease or injury	Dag to for as a somet	(uacica-ory						
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a consec	quence of):					-1-	
68760	sicial			đ							
89	ifficati g phy as the	Medical		V							
Вох	eath certific attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnature 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnance			23d. Da	te of delive	ry
B	deat	sicie	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4 Pregnant at time of c		Other (specify)	<i>y</i>		Mo	onth	Day Year
P.O.	s that the death cer ned by the attendir s detached for use	Physician/	9 Unknown								
	es th igned be de	by	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause giv	ren in Part I.			ribute to th	e cause of death?
ord	w require been sign should t	ted						10	res 2⊠No	3 Proba	ably 4 Unknown
Ö	law ras be	Completed						24a. Was autop	an 24b.	Were autop	osy findings available
<u> </u>		Son						perfo 1 ☐ Yes	rmed?	death?	2□ No
/Ita	nysician: Th nis certificate I director, pag	Be	25. Was case referred to medical examiner?	112-1			26. Place of Deati	Check only o	пеј		
5	this al di	5	1 ☐ Yes 2 ☐ No		ER/Outpatien		4 Li Nursing no)
Division of Vital Records,	if or Attanding Physician: after death. Director: After this certific: d in by the funeral director,	lon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2 □ No	28d. Describe f	now injury occur	red	
<u>s</u>	death death ctor: y the	ficat	3 Suicide 6 Could not be		ome farm str			28f. Location (Street and Numb	er or Rural	Route Number
2	Difte o	Certification:	4 Homicide determined	building, etc. (Specil	ý)	out, radiory, omog		City or Tox	vn, State)	or or marar	riodio ridiliber,
	a Hospitel (24 hours a Funeral Dietely filled i		29a. Certifier 15 Certifying Ph	ysicien: To the best of my kno	wiedge, death	occurred at the tir	ne, date and place,	and due to the	cause(s) and ma	anner as sta	ated,
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medical Exam	niner: On the basis of examina and manner stated.	ition and/or inv	estigation, in my o	pinion, death occurr	ed at the time,	date and place,	and due to	the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	(/		29c. Licens			29d. Date signed		
	(1 Andr	M			D63738		May 8,	200	6
)		30. Name and address of person who	·		•	7 ~1-	- ·		207	
			Dr. Anjuman Ar				ad, Silve	r Sprin	g, MD 20	0910	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 1 2	2006 32. Segistrar's Signa	S. As	and I					
	- C 100			Interest of	-						

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Maryla	ınd / Departn <i>Certifi</i>	nent of He cate of D	alth and N <i>eath</i>		ene2006	1666
Physic		1. Decedent's Nam <i>e (First, Middle, La</i> s Mattie Queen Est	•				2. Date of Death Month 05 0	Day 2006	3. Time of Death 11:35 P M
/Med Exam		4a. Facility Name (If not institution, give Casey House	street and number)		City, Town, or L			4c. County of Death	1
Funera Directo		241-42-0740	7. Age (<i>ln yr</i>		Inder 1 Year nths Days	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 02/24/19	9. Birth Ha¶	place (State or Foreig
Maryland I-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County DC None	10c. (City, Town or Location Washir					10d. Inside City Limits
th with the 23a or 28s	Funeral Director	10e. Street and Number 5233 N. Capitol S	Street N.E.		of. Zip Code 20011		10g	g. Citizen of What Cou USA	intry?
Deficiency (Mary Italia & I. & I. 2-00.30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "nature!, or items 23s or 28s-1 show eny loipty or other treumatic event, the Madical Execution to motified at mone.	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B1a	, etc.
d Z IZ I 3-0030 filed within 72 hours aff Hygiene ther then "naturel", or ont, the Medical Exercit	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's (Give kind of life. DO N	Usual Occupation of work done dur OT use retired) Service	on ing most of work	1	b. Kind of Business/li U.S. Gover	
Maryiano id 2 should be filed ith and Mental Hyg 27 le marked other treumatic event,	To Be C	17. Father's Name (First, Middle, Last) Errie Shipman			1		e (First, Middle, Ma Thurman	iden Sumame)	
i, Widir yid and 2 should ealth and Men n 27 le marke ier treumatic		19a Informant's Name/Relationship (T Linda R. Brooks	ype, Print) Daughter	19b. Mailing Add 2023 Ra Silver	dress (Street and andolph Spring,	Number or Ryr, Road #2 MD 209	al Route Number, 0 201 902	City or Town, State, Zi	p Code)
Dallillore, Dermit. Pages 1 av Depertment of Hea mportent: If Item eny Injury or othe	,	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,)	Place of Disposition cemetery, crematory allsboro Mark	(Name of	1	Date 20	c. Location - City or T allsboro,	own, State
permit. Depertr Import		21. Signature of Funeral Service Licens	reme	22. Nan Latn	ey's Fu	neral Ho	ome Wash	Georgia A ington, DC	
Physician /Medica Examiner	er	23a. Part1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury)	ne cause on each line.	ancreatic equence of):			, toopilatory allow		Approximate Interval Between Onset and Death
ificate be executed g physicien and as the burial-transit	edical Examin	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
death certi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 □Ectop	pic pregnancy or (specify)			23d. Date of deliv	ery Day Year
law requires thet the es been signed by the 2 should be detached.	b	Part II. Other significant conditions co	ntributing to death but not re	esulting in the underly	ing cause given	n Part I.		cco use contribute to t	
The ate h	Completed						24a. Was an autopsy performe	d? prior to co	opsy findings available impletion of cause of
Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2[☐ ER/Outpatient 3[DOA Other:		n <i>Check only one</i> me 5 ☐ Residence	X Hosp e 6∐Other(Specif	Įсе
ding After	Certification; 7	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		28d. Describe how		<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>
- 5 2 - c		4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)			City or Town, S		
To the Hospital of within 24 hours of To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my kr ner: On the basis of examir and manner stated.	nowledge, death occu nation and/or investiga	rred at the time, ation, in my opini	date and place, a on, death occurre	and due to the caus ed at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
To th To th comp	Me	29b. Signature and title of certifier		MD	29c. License no D35635			Date signed (Month, 5/08/2006	Day, Year)
٦		30. Name and address of person who co Joseph Kaplan	ompleted cause of death (Ite	em 23a) (Type, Print)	6001 N Rockv	luncaste 11e, MD	r Mill Ro 20853	ad	
St Regis	ate	31. Date filed (Month, Day, Year) MAY 1 1 20	32 degistrar's Sign	nature Sheet	E)				

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 5 ALLARD /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical MICOMICO MAH4 CNINSULA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F 213-22-77/3 Usual Residence of Decedent Director 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 23a or 28e-f ahow injury or other traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes 2 No by Funeral Director SOMERSE NCESS 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 28405 SA 12. Was Decedent Ever in U.S. Amed Forces?
1 ☐ Yes 22 No or itema 11. Marital Status 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) DHNZON RANKlik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALLARD Control Process Auge 28405-DAUGHTER VENTON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department of important: If any injury or once. 5 15/06 FM. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BENNIE 5ABELLA 2180 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Offset and Death Immediate Cause (Final disease or condition resulting in death) Aspiva **Physician** /Medical Due to (or as a consequence of): Examiner Esquentially list on drions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate has been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2□ No Division of Vital 1 Tes To the Hoapital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number lan w-in 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1340 CONSTATO2

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 5 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene [] [For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month David May 17, 2006 B1ume 1:55 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11500 Old Mt. Pleasant Road, NE Cumberland Allegany 7. Age (In yrs. last birthday) H Under 1 Year If Under 24 Hrs.
51 Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 51 Yrs Director 213-64-9857 11/26/1954 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show disal Examiner rount by notified at 1 ☐ Yes 2 No Directo MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Items 23a 11500 Old Mt. Pleasant Road, NE permit. Pages 1 and 2 should be filed within 72 hours atter death 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "natural", or Items 23a any injury or other traumatic event, the Mental Examiner rusts and DECE. 21502 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samue1 Lawrence Blume, Sr. Mona Catherine Cole ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Camille L. Blume / wife 11500 Old Mt. Pleasant Road, NE., Cumberland, MD2150 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Mem. Park 05/21/2006 Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD about Moms 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STAGE LYEARS CND /Medical Due to (or as a consequence of) Examiner S. uentially list confirms if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physicien and s the burial-transit The lew requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Partil, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 □Unknown ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 NResidence 6 Other (Specify) မှ 1 ☐ Yes 2 ☑ No 3□ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No ector: by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) W2627 D31875 May 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Welik, M.D., 904 Seton Drive, Cumberland, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY 1 9 2006

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment <i>rtificate</i>			and M		giene Reg. No.	006	1667
	Physicia /Medic		1. Decedent's Name (First, Middle, Las RICHARD LORING							2. Date of De. Month	ath Day	Yeav OC	3. Time of Death
	Examin		4a. Facility Name (If not institution, give LIONS MANOR NUR	SING HOME		CUM	BERI	Location of			A	County of Dea	Y
	Funeral Director		5. Social Security Number 6. S 019–20–4436	ex 7. Age M 2□F	79 Yrs.	If Under 1 Months	Year Days	Hours	Min.	8. Date of Bir (Month, Da MAR • 6,	y, Year)	_ Co	thplace (State or Fore ountry) SACHUSETTS
Maryland	a-f ehow	tor	10a. State 10b. County MD ALLEGA	NY	10c. City, Town or Le								10d. Inside City Lim 1 ☐ Yes 2
with the	3a or 28 at be not	al Dire	10e. Street and Number 941 BISHOP WALSH	ROAD		10f. Zip (code 502					en of What Co	ountry?
:1 Z15-0036 within 72 hours after death with the Maryland	ral', or items 23a or 28a-f ehov Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married X Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1)XYes 2 N If Yes, Give Year or Dates: 0	WWII	Was Decede If Yes, speci 1 Yes 2	fy Cuba	spanic Origin, Mexican Specify:	gin? (Spe n, Puerto f	cify Yes or No Rican, etc.)		4. Race - Ame Black, Whit Specify:	
d within 72 hours af	t of Health and Mental Hygiene. If item 27 is marked other than "natural", or other traumatic evant, the Modeal Ex-	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual kind of work DO NOT use OF QUA	doné a retired,	uring most			KEL	d of Business LY—SPR E COMP	INGFIELD
7 = =	and Nental Hygiene. is marked othar than sumatic evant, II's M.	To Be C	17. Father's Name (First, Middle, Last) MTLTON BALL							(First, Middle,	Maiden S	Витате)	
	Health and lem 27 is me sther traums			Type, Print) IFE		O. BOX	309		CUMI	Route Number	, MD	2150	1
<u> </u>			20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	/2006	LA	ation - City or							
ם מ	Department Important and injury		21. Signature of Funeral Service Lice	Loxhur		202 (REE	NE ST	CREET	HOME, I	ERLAN	ID, MD	21502
	nysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	the death. Do not en	ter the mode	of dying	g, such as	cardiac o	respiratory a	rrest,		Approximate Interval Between Onset and Death
	physician and sthe burial-transit	al Examiner	Sequentially list conditions, if any making to min-orbits cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. En Due to (or as		rkin	180.	J'S (Dise	48E =			YEARS
D. BOX o	led by the attending physical detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	⊒Ectopic pre ⊒ Other <i>(spe</i>					23	3d. Date of de Month	livery Day Year
ras, F.	been signed by	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the t	underlying ca	use give	on in Part I.		23e. Did t			o the cause of death? robably 4 □Unkno
I Records,	ate has been page 2 shoult	Completed								24a. Was autor perfo		24b. Were as prior to death?	utopsy findings availa completion of cause of
of Vital	this certificate al director, pag	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	nt 3 DO	Othe	. /		(Check only only only only only only only only		□Other (Spe	cify)
DIVISION OF	death. ctor: After	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b determined		y Year) Injury	М		at ? ∕es 2 □	No	28d. Describe how injury occurred			
Hoenite	within 24 hours after To tha Funeral Dirac completely filled in by	Medical Ce	29a. Certifier 1 Check only one)	nysician: To the best on the basis of and manner sta	of my knowledge, dea f examination and/or in ated.	th occurred anvestigation,	t the tim	e, date an binion, dea	nd place, a	nd due to the ed at the time,	cause(s) a date and p	and manner as place, and due	s stated. e to the cause(s)
Tothe	/イイ/V within comple		29b. Signature and title of certifier) mabl	mo	1	License	number 2 0 5	4		29d. Date	signed (Mont	th, Day, Year)
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DHMH 17 Rev 1/2001

ORIGINAL MUSICY BOUGH LPN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #22 Per FH G858 8/03/06 Jn. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year WILLARD CLEVES CRABTREE 05 09 9:55 AM 06 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cumberland Allegany Heart Hospital Sacred If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 □ F 85 212-18-1841 Vrs Sept. 20,1920 Mary land Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Morgan Paw Paw 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3165 Paw Paw Road 25434 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 \(\) No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Auto Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **Elwood Crabtree** Ida Platt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Crabtree - wife 3165 Paw Paw Road Paw Paw, WV 25434 20b. Place of Disposition (Name of cometery, crematory or other place)
Sulphur Springs
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/13/2006 Kiefer, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 188 Mosser Avenue 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Kimble Funeral Home Paw Paw, West Virginia Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death RESPIRATORY IDAY Due to (or as a consequence of): HRONIC OBSTRUCTIVE Lung Disease Exacerbation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): CAILURE ONGESTIVE Due to (or as a consequence of) FIBRILLATION 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

signed by the attending physician and deed detached for use as the burial-transit 68760 Box (Records, been si of Vital after

certificate has b lirector, page 2 s ours after death. leral Director; After this certific filled in by the funeral director, within 24 hours a To the Funeral I completely filled

Physician

/Medical

Examiner

WV

Funeral

Director

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Maryland 21215-0036

Baltimore,

1 and 2 should be Health and Mental is marked

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai once.

Physician

/Medical

Examiner

Physician/Medical

Completed by

Certification:

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Funeral Director

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Registrar

SABAHAT NAWAS

MN

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiniter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 51912006

58655

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. 32 Corporate 3 / Registrar's Signature

Grantsville

31. Date filed (Month, Day, Year) MAY 1 9 2006

29b. Signature and title of certifier

29a. Certifier

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certificate	of Death			Reg.	No.	JUb ibb/			
Physicia	an/	1. Decedent's Name (First, Midd						Date of Death Month D	ay Yea	3. Time of Death			
Medical Exami	ner	KENYAH LYNI			T., 6: 7		N.	1ay 18, 200	6	1050 hrs			
		4a. Facility Nation (if not institution Upper Chesapeake M	ledical Center		4b. City, Town, o				Ac. County of Death Harford MM/DD/YYYY) 2 2005 10d. Inside City Limits 1 X Yes 2 No Citizen of What Country? UNITED STATES 14. Race - American Indian, 8lack, White, etc. Specify: WHITE State of 8usiness/Industry Den Surname) 7. City or Town, State, Zip Code) ARYLAND 21040 De. Location - City or Town, State HAVRE DE GRACE, MD P. A. DE GRACE, MD P. A. DE GRACE, MD P. A. DE GRACE, MD 23d. Date of delivery Month Day Year				
Funeral		5. Social Security Number	6. Sex 7. Age (In yrs. last birthday		ear If Under	r 24Hrs. 8. Min.			Foreign			
Director		214-73-1810	1 M 2 XF		Yrs. 10 2		IVIII.	06/22	2 2005	Country MARYLAND			
à	ŀ	Usual Residence of Decedent 10a, State 10b. County	<u></u>	Dc. City, Town or Lo	ocation					10d Inside City Limits			
			ARFORD	50. O.G, 10 5. E.	EDGEWOOD	1							
Varyland 28a-f show any d at once	흸	10e. Street and Number	ARTORD		10f. Zip Code			100	Citizen of Wh				
0036 within 72 hours after death with the Maryland jone ner than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	Director	1902 ELOISE	LANE		13.1 2.15 3333	21040	0	l log.					
h witl	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H								
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5-0036 led within 72 hours after bygiene other than "natural" the Medical Examine	호	15. Decedent's Education (Spe	or Dates:	eted) 16a, Dece	edent's Usual Occup		ind of work	done 16					
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5-00 led wit Hygien other the M		17. Father's Name (First, Middle	, Last)	•				st, Middle, Mai	den Surname)				
21215-0036 ould be filed within 7 I Mental Hygiene is marked other than it event, the Medical	B	UNKNOWN					RI COO						
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental tant: If item 27 is marked or other traumatic event,	٩	19a. Informant's Name/Relations SHERRI SYDNOR											
re, s l and f Heal f item		20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Removal from State		sposition (Name of our other place)	cemetery,	Da		0c. Location -	City or Town, State			
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alt mit.	1	21. Signature of Funeral Service	Licensee	2	22. Name and Addre			HOME	D A				
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8760, ifficate bong physicas the burns the burns of the b	ΣI	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnancy					23d. Date of	delivery			
68 certifi	ian	past 12 months?	I Live birth	ne of death 5	1	BEctopic	pregnancy		Month	Day Year			
Box 68 e death certi the attendin ed for use a	Physicia	1 Yes 2 No 9 Un	known 9 Unknown	5	Other (Specify)								
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Division of Vital Records, tal or Attending Physician: The law requirers after death. **I Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	Completed							performe	<u>d</u> ? d₁	eath?			
tal Recian: The certificate extor, page		25. Was case referred to medica	lal la		26.Pla	ce of Death (Check only]NO]	Yes 2 No			
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of of ing Ph	1, 1	27. Manner of Death	28a. Date of Injury (Month, Day,Year	28b. Time	of Injury 28c. In	jury at Work?	? 28d	. Describe how	injury occurre	ed e			
ision Attendii r death. rector: A	텵		ding Fnd 5/18/2		.0:10 am ¹□	Yes 2 X	No ur	ıknown					
ViSi or Att frer d Direct	iji	2 Accident Inve	20a Bloom of Injur	y - At home, farm,	street, factory, office	building, etc		Location (Stre	et and Numbe	er or Rural Route Number, City			
Divi Hospital or 24 hours afte Funeral Dir tely filled in	Certification:	4 Homicide dete	ermined (Specify) for	ound at hom	<u>e</u>		Edg	or Town, State Sewood, M	D 1902 1	Tourse Lake			
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To the Within 2 To the Complet	Medical		and manner stated.	nation and/or inves			uned at the						
	2	29b. Signature and title of certific	() ^ n			nse number				ed (Month, Day, Year)			
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0		 Name and address of persor Patricia Aronica-Polla 		ath (Item 23a) dical Examine	r 111 Penn S	Street. Bal	ltimore. N	MD 21201					
S.	ate	31. Date filed (Month, Day, Year)											
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			For State Registrar	State of Ma	ryland /		rtment tificate			and M	1	Reg. No.	06	16675
37	Physici		Decedent's Name (First, Middle, Last) Rita Cecelia Cla								2. Date of Dea Month May	Day O	Year 2006	3. Time of Death 2:30 P M
-	/Medic Examin		4a. Facility Name (If not institution, give : Anne Arundel Medi		r		4b. City, To		Location o		incly	4c. Coun	ty of Death Ine Ar	
g de	Funeral Director		5. Social Security Number 6. Security Number 164–12–7521 Usual Residence of Decedent	7. Age	(In yrs. last bi	Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day NOV. 24	, Year) 1, 1911	9. Birth; Coul M	place (State or Foreign ntry) aryland
	a-f show	ctor	10a. State 10b. County Maryland Anne Aru		10c. City, Tov	wn or Loca	ation	Anı	napol	is				10d. Inside City Limits 1 XYes 2 □ No
	th with the 23s or 28	Funeral Director	10e. Street and Number 680 Americana Dri	ve, Apt. 5	56		10f. Zip C		21403	}		10g. Citizen o	What Coul	
980	filed within 72 hours aftar daath with the Maryland Hygian. ther than Insturel', or Items 23e or 28e-f show ont, the Medical Examinational be notified a	þ	11. Marital Status 1☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2XXII If Yes, Give Year or Dates:			as Decede Yes, specifi		panic Original, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Ra BI Spec	ace - Americ ack, White, ify: W	
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Maryland	a d a b	To Be C	17. Father's Name (First, Middle, Last) Charles F. Clark	son							(First, Middle, ta Barb	Maiden Suma		
	gas 1 and 2 should t of Haalth and Man if Itam 27 is marke or other traumatic		19a. Informant's Name/Relationship (Ty Frank Clarkson/b		191	b. Mailing	Address (Street at ana	Driv	r or Rura e, A	APt. T-6	r, City or Tow Anna	n, State, Zip polis	Code) , MD 21403
Baltimore,	Pagas 1 and nant of Harmint: If Itam		20a. Method of Disposition **XXBurial 2		20b. Place of cemeter St. Ma	ery, crema	atory or oth	er place			oate 5/2006	20c. Location Annapo		own, State Maryland
Balti	permit. Pagas Dapartmant of important: If It any injury or once.		21. Signature of operal Service License	" Lile	Ze~				of Facility	Joh	n M. Ta	ylor F	unera	1 Home , MD 21401
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Divis	7 9 7 0	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, f (Specify)	farm, stree	et, factory, o	office			28f. Location (S City or Tow	treet and Nurr n, State)	nber or Rura	d Route Number,
	To the Hospital or within 24 hours afte To the Funaral Dir complately fillad in	Medical	29a. Certifier d'Certifying Physical (Check only one)	sician: To the best of ner: On the basis of a and manner state	examination at	ge, death o	occurred at estigation, in	the time	o, date and nion, deat	d place, a	and due to the d ed at the time, o	ause(s) and n late and place	nanner as si	tated. o the cause(s)
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			30. Name and address of person who co	Sulliva	an) (Type, P	rint) Av	ino	Av	un	del M	eclico	0 6	inter
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	2	Lank.	<i>y</i>						

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Phillip Vito Cosenza MAY 9 2006 4:07 /Medical Α 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MEMORIAL HOSPITAL ALLEGANY CUMBERLAND If Under 24 Hrs. If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1⊠M 2□F Director 107-36-1995 Yrs. 59 05/19/1946 New York Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ul Hygiene. other than "natural", or flems 23e or 28e-f ahow vant, the Mudical Examitier must be notified at Director 1 Yes 2 No Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Route 6, Box 6577 (Old Mead Chapel Rd) 26726 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. by 3 ☐ Widowed 4 🎇 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Automobile Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 end 2 should be filment of Health and Mental Hant: If Itam 27 is marked ott jury or other traumatic avan Be Cosenza Nicholas Peter Filomina Lucy Caccadzano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Cosenza Route 6, Box 6577, Keyser, West Vir inia 26726 / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Depertment o Important: If any Injury or once. Cumberland Crematory 05/09/2006 4 □ Donation 5 □ Other (Specify) Cumberland, MD 21. Signature of Fundral Service Liquinsee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a HEPATOCELLULAR CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, harry, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed burial-transil and Due to (or as a consequence of) the attending physiclen ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has autopsy performe 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death | Check only one) examiner' Hospital: 1 ⊠Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred or Attanding s effer de... al Director: Atte 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, arm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours of To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36766 MAY 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nds DR.VIK POONAI 924 SETON DRIVE CUMBERLAND, MARYLAND 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 Registrar

Division of Vital Records, P.O. Box 68760,

			_	Type or Pri					-	-		16677
			1 - State Registrar	State of Maryland / Department of Health and Mental Hygiene [] [] [] [] [] [] [] [] [] [10011		
	Physici /Medi		Decedent's Name (First, Middle, La Edna	Blanche			Cessna	Month	nay 9,2006 1340 M			
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	Funeral Director		Social Security Number 6.	Fig. 10 Age (in yrs. last birthday) 7 Age (in yrs. last birthday) 7 8 Yrs.			If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) 03/08/1928		hplace (State or Foreign	
	pu k		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	um or Lo	antion		103/08/	1920	Pen	nsylvania
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ore,	of Heal		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of natory or other pla		Date Date		tion - City or	26753 Town, State
Baltimore,	ment cant: If tant: If Jury or		1 ⊠ Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci	fy)		lawn	Mem. Gar	rdens 05/			Vale,	MD
Ball	permit. Pages 1 and 2 sh Depertment of Health and Important: if item 27 is m sny injury or other treum once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502									
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al Records,	or Attending Physician: The la viter death. Director: Atter this certificete has in by the funeral director, page 2	Completed	3 Hypertension					24a. Was autop perio 1 Yes	autopsy prior to completion of cause of death?			
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ion of			27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ıry 28b	Time of Injury	28c. Injur Wor		28d. Describe h			ny)
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	To the Hospital within 24 hours et To the Funeral I completely filled	Medical (29a. Certifier (Check only one) Check only one)								stated. to the cause(s)	
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	MAS 30, Name and address, of person who/completed cause of death (Item 23a) (Type, Print)							5/9	1/06			
k y	→ H.	-	30 Name and address of person who are Christophe 31. Date filed (Month, Pay Year)	Vagnor	death (Item 23a	1 S	1.	rive, a	umberla	nd, t	laryla	and 21502
	Registi	ar	11111 1 0 7	000	المائر السائلان	100	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month SUK YEN CHO CHEUNG MAY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 □ F 087 52 2170 93 Director AUG 8, 1912 S KOREA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiane. Important: If item 27 is marked other than "natural", or itama 23a or 28a-f ehow any Injury or other fraumatic avant, the Madical Examinat must be notified at outs. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD MONTGOMERY GAITHERSBURG 1√2 Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20886 19301 WARKINS MILL RD U.S.A Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No Specify: Specify: ASIAN 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 TEACHER KOREAN GOVI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NAM JOON CHO JYUNG ၉ JΑ LEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11725 AUTH LANE SILVER SPRING CHEUNG / SON KUNHO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) NORBECK MEMORIAL 5/12/06 OLNEY 21. Signature of Funeral Se 22. Name and Address of Facility CHARLES HINDS FUNERAL SERV 12303 KAYAK DR UPPER MARLBORO MD 20772 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final **Physician** disease or condition resulting in death) hous /Medical Due to (or as a consequence of): Examiner PSVS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) neumania ettending physicien and Due to fr as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide within 24 hours e 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. D0062435 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) 7878/50 year M-EISOYYX 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certific	cate of	Death		Reg. No	200	6 667	
Physici Nedical Exami		Decedent's Name (First, Middle,Last)				Month	Date of Death Month Day Year			
medicai Exami	mer	Wilbur Conway Carr 4a. Facility Name (if not institution, give street and nur	mber)		o. City, Town, or Location	May 9, 2	May 9, 2006 1715 nrs			
		Peninsula Regional Hospital	iniber)	**	Salisbury	or Death	th 4c. County of Death Wicpmicp			
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr				Birth(MM/DD/\	YYY) 9 Birt	hplace (State or	
Director		225-28-3783 1X m 2 F 87 Yrs. Months Days Hours Min. March 19, 1919 Foreign Country) VA								
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ow any		10a. State 10b. County 10c. City, Town or Location						10d Inside City Limits		
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leath r item	Funeral	1 Never Married 2 Married Armed Fo	rces?	If Yes	s, specify Cuban, Mexica	n, Puerto Rican, etc.)		White, etc.	Salt Waldin, Didox,	
after al", o	by F	3 X Widowed 4 Divorced If Yes, Give Year or Dates:		1 🗌 🕥	res 2 X No specify		Spec	cify: Whi	ite	
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5-0036 led within 72 Hygiene. other than	Com	Heavy Equipment Operator Excavatio 17. Father's Name (First, Middle, Last) Heavy Equipment Operator (First, Middle, Maiden Surname)								
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medical	To Be (Aubrey C. Carr			Ren	a Carr				
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Dre, MD 21215-0036 os I and 2 should be filed within 72 hours after death with the Maryland let let than 18 Myell House 19 Myell and 18 Myell and 18 Myell and 18 Myell and 18 Myell and "natural", or items 23a or 28a-15th her traumatic event, th. Myelical Examiner must be notified at once		Serena L. Morgan (Daugh			Whitesvill on (Name of cemetery,	e Rd. Del				
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Baltimo permit Page Department (Important: injury or otl		4 Donation 5 Other Specify	Line	Churc	h Cemetery	May 13, 20	06 De1	mar, [elaware	
Balt permit Departi Importi		21 Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home								
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/Medical		failure. List bely one cause on each line Immediate Cause (Final disease a. Chest Injuries complicated by Hypertensive Arteriosclerotic Cardiovascular Disease Death Death								
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687 ertifice ding p	an/I	23b. Was decedent pregnant in the past 12 months?	rth		death 3 Ectopi	c pregnancy	Mont	e of delivery th Da	ay Year	
Box 687 c death certificathe attending get for use as the	past 12 months? The Live Diff 2 Fetal death 3 Ectopic pregnancy Month									
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Division of Vital Records, P.O. Box 68760, within 24 buspital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as started.								
To cor.	Me	and manner stated 29b Signature and title of pertifier 29c License number 29d Date signed (Month,								
	1	O.C.M.E. May 11, 2006								
3	4	20 Name and address of person who completed cause of death (Item 23a)								
5		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
	State 31. Date filed (Month, Day, Year) Registrar MAY 1 5 2006 32. Registrar's Signature									
Regist	uell	14171 T 0 7000 KM	REPORT AS	110.9	William .					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Dav

-2006

4c. County of Death

USA

100m1co

Maryland

14. Race - American Indian. Black, White, etc.

white

Approximate Interval Between Onset and Death

23d. Date of delivery

2 No

BUX 1733 Solish MD 21802

Dav

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

Year

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 X No

10

Core

1. Decedent's Name (First, Middle, Last)

D.

William

Physician

DHMH 17 Rev 1/2001

Deserle

12

2006

31. Date filed (Month, Day, Year)

State Registrar se of death (Item 23a) (Type, Print)

caste

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month MAY **Physician** 14, 2006 91/7 P.M HUBERT DAILEY CANNON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY 110 PARK STREET, APT. CUMBERLAND | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | APRIL 13,1933 | WEST VIRGINIA Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1<u>X</u>M 2□F 236-50-0760 73 Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Apone Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.
and it if item 22 is marked other then "natural", or itema 23s or 28e-1 show and it of the marked other then "natural", or itema 23s or 28e-1 show any or other traumatic avant, its Madical Examinate must be notified at 1X Yes 2 No ALLEGANY CUMBERLAND **Funeral Director** MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 U.S.A. 110 PARK STREET, APT. #2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Be Completed by WHITE 3 ☐ Widowed 4 🎖 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) KOPPERS CO. LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BUNNER CECIL PITTMAN CANNON NELMA ORPHA ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 110 COUNTRY VILLA, FORT ASHBY, WV BEULA WRIGHT / SISTER 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of P Important: If its any injury or of once. CUMBERLAND CREMATORY 05/17/2006 CUMBERLAND, MD 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A. 21. Signature of Funeral Service 202 GREENE STREET, CUMBERLAND, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HOUTE **Physician** MA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MANONO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical as the ettending a tF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) signed by the eld be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Donknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy 2 X No 1 ☐ Yes ne Huspr.... in 24 hours altar deatr. the Funeral Director: After this cartificate the Funeral director, pr 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Medical Certification; To 27. Manner of Death 28a. Oate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 14 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated within 2 To the 29b. Signature and title of certifie 2 leted cause of death (Item 23a) (Type, Print) 30. Name and address of 912 FITON MILE CUMBERLAND MD 21502 MD nas VERLASP. 1050 Registrar's Signature State Registrar

	1 - State Registrar	State of Mary		rtificate of		Reg.	7000	16682
cian lical	Decedent's Name (First, Middle,	Evelyn F.	Costa			2. Date of Death Month May 7, 2	Day Year	3. Time of Death
iner	4a. Facility Name (If not institution,	, give street and number)			or Location of Dea	th	4c. County of Dea	lh
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	10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
Funeral Director	Maryland Anne A	rundel	Ar	napolis				1 ☐ Yes 2 XNo
Dire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
rai	2543 Sandy Run				401		USA	
בֿ בֿ	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie	12. Was Decedent Ever Armed Forces? ed 1 ☐ Yes 2 🕅 No		Was Decedent of II Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ami Black, Whi	
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င္ပ	17. Father's Name (First, Middle, L	2 years	Se	ecretary	18 Mother's Na	me (First, Middle, Mai	ublic Sch	noots
o Be		'ilippelli				ette Basil	,	
- (19a. Informant's Name/Relationsh		19b. Mailir	ng Address (Stree	at and Number or F	lural Route Number, C	ity or Town, State,	Zip Code)
	William M. Cost	a. Sr./ Husbar				Annapolis,		
	20a. Method of Disposition	20	b. Place of Dispo				Location - City or	
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	23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caused the conly one cause on each line.	death. Do not ent	er the mode of dy	ring, such as cardia	c or respiratory arrest,		Approximate Interval Between
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Examiner	that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
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30 €	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		Ectopic pregnanc			23d. Date of de	livery
Physician/Medical	in the past 12 manths?	4 Pregnant at time		Other (specify)			Month	Day Year
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ò	Part II. Dther significant condition	ns contributing to death but not	resulting in the u	nderlying cause g	iven in Part I.		1.0	the cause of death?
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2						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Completed						performed		2□ No
Be	25. Was case relerred to medical examiner?	Hospital:			26. Place of De	ath (Check only one)		
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:: To	1 Natural 5 Pending	(Month, Day Yea	r) Injury	VVC	ork?]Yes 2∐No	28d. Describe how it	nary occurred	
		ation						
	2 Accident investigated and Suicide 6 Could no	ot be 28e. Place of Injury -	At home, farm, str			28l. Location (Street	t and Number or Pi	aral Route Number
	2 Accident investiga	ot be	At home, farm, str ecify)			28l. Location (Stree City or Town, S	t and Number or Ru tate)	ural Route Number,
Certification:	2 Accident investigated a Suicide a Homicide investigated a Gould not determine the Accidence of the Accidence of the Accidence of the Accidence of the Accidence of the Accidence of the Accidence of the Accidence of the Accidence of the Accident of the Accidence of the Accidence of the Accidence of the Accident of the Accidence of the Accident of t	ot be ned 28e. Place of Injury - building, etc. (Sp	ecify) knowledge, death	eet, lactory, office	time date and place	City or Town, Si	(ate)	bateta:
Medical Certification: To	2 Accident investigated a Suicide a Homicide investigated a Gould not determine the Accidence of the Accidence of the Accidence of the Accidence of the Accidence of the Accidence of the Accidence of the Accidence of the Accidence of the Accident of the Accidence of the Accidence of the Accidence of the Accident of the Accidence of the Accident of t	ot be ned 28e. Place of Injury - building, etc. (Sp	ecify) knowledge, death	eet, lactory, office	time date and place	City or Town, Si	(ate)	s stated

State Registrar 31. Date liled (Month, Day, Year)

MAY 1 0 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

D 79675 Ralph V. Boccia, M.D.

			For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment of H	ealth and N Death	/lental Hy	giene Reg. No	-	6	166	83
F	72	* A	1. Decedent's Name (First, Middle	, Last)					2. Date of De			1005	3. Time of	Death
	Physici	600 .	Elsa Carmela	Duđa					May 6	, Da	006	rear	2:40	рм
	/Medic	1.66	4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Town, or	Location of Death		4c.	. County of	Death		
			803 Bonifant	Street			Silver	Spring			Montg	jome:	ry	
100	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth	8	9. Birthpi Coun	ace (State o	r Foreign
	Director		172-32-3775	1□M 2፟EF	67	Yrs.	World Day 3	Tiodis items.	April 2	27,19	939 P			ia
9			Usual Residence of Decedent		100 0	in Town or L	- ation					4	Od. Inside C	it Limite
roja.	show Lat		10a. State 10b. County		100. 0	City, Town or Lo	cation					'		2 □ No
M	Page 1	cto		gomery	Si	lver Sp								
ith t	or 2	Director	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of Wh	nat Coun	try?	
death with the Maryland	238		606 Bonifant S				20910				USA			
	teme in to	Funeral	11. Marital Status	Armed F		U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	D-	14. Race - Black,	White,		
So affe	or i	by Fi	1 Never Married 2 Marr	If Yes, G	2X No live		1 ☐ Yes 2 忆 No	Specify:			Specify:	Whit	- 0	
2-UUSO	urai		3X Widowed 4 Divorced	Year or	Dates:	160 Dage	dent's Usual Occupa	ntion		16h K	and of Busi			
IZ I D-UUSO	THE SE	lete	15. Deceden (Specify only highes	st grade completed)	(Give	kind of work done of DO NOT use retired	during most of world	king	100. K	illu or busi	ilies 2/11/0	iustry	
	than	Completed	Elementary/Secondary (0-12)	College 5-	(1-4or 5+)		ltor	,		R	Real E	Cetai	+ o	
N 00	the r		17. Father's Name (First, Middle,			Red	ICOI	18. Mother's Nam	e (First, Middle	1			<u> </u>	
_ 4	od o	o Be	Carmine Gualt					Dora R	ive					
2 2	of Health and Mental I f Item 27 is marked of r other traumatic eve	ĭ	19a. Informant's Name/Relations			19b. Maili	ng Address (Street a			er. City o	or Town. St	tate, Zip	Code)	
Na S	T is			UNDERSTANDING STREET, WITH		11				5 . 96				
a , 2	Heal em 2 ther		Kimberly Hope 20a. Method of Disposition	Lake/Dauc	Jhter 20b.	Place of Dispo	Harding of Name of		Date		ocation - Ci			
0	- E = 5/		1 Burial 2 Cremation			_*.	matory`or other place even Cemete:	May	11,		_			_
Haitimore,	Department of H mportant: If ite		4 □ Donation 5 ♣ Other (S 21. Signature of Funeral Service		ient Ga								, Mar	yland
	Depa Impo		Gru y	Scere	10	F f 50	ancis didies ancis didies O Univers	Collins ity Blvd	Funeral , W., S	Hom ilve	e Inc	ing	, MD 2	20901
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea	ath. Do not ent	ter the mode of dying	g, such as cardiac	or respiratory a	arrest,			Approximat Interval Bet	ween
P	hysician		Immediate Cause (Final disease or condition	77		. T3 / 3 /	7.1.+ d						Onset and Emmed i	
	Medical		resulting in death)		o (or as a conse		llation						rillieoj	
E	xaminer		Sequentially list conditions,	b. Card	diomyopa	athy							Years	
7	=	ner	ri any, leading to immediate cause. Enter Underlying	-Due to	(or as a conse	equence of).								
đị.	nd trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	с										
Ö,	ian a		resulting in death, cast	Due to	o (or as a conse	equence or):								
876U,	hysician and the burial-transit	dical		d	_							-		
0 1	attending p		IF FEMALE:	20. 1/							m - 2-3			
Box 6	ttend or us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of preg birth 2 Pe	tal death 3	Ectopic pregnancy				23d. Date of Month			Year
S	9 6 9	Sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Preg 9□ Unk	gnant at time of tnown	death 5L	Other (specify)			- 13			,	
ords, P.O	d by	Ph	Part II. Other significant condition	one contributing to	death but not re	aculting in the u	andorhring cause ave	on in Part I	23e Did	tobaccou	use contrib	ute to th	e cause of o	death?
Š,	signed be det	b	Partiti Other significant conditi	Jis contributing to	dealii bat iiot ii	saling in the d	indenying cause give	piritir divi.				Prob		Unknown
oro	peen si	eted								103 2	1			
e c		n di							24a. Was	psy	24b. We	or to cor	osy findings apletion of c	available ause of
ř ș		Completed							1 ☐ Yes	ormed? 2√□ No	, 1	ath?] Yes	2 🗌 No	
of Vital Records,	certificate rector, pay	Be	25. Was case referred to medica examiner?				100	26. Place of Dea					Real	Estat
	this c	P	txTxYes 2 □ No			ER/Outpatie		4 Nuising n					Prope	rty
Division of	After funera	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	.9	e of Injury onth, Day Year)	28b. Time o	Worl		28d. Describe	now inju	ry occurred	d		
Sio	death.	cati	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be				Yes 2 □No	006 1	(0)	- 111 - 1			
$\sum_{i=1}^{\infty} \frac{1}{2}$	s after death.	Certification:	4 Homicide determ	nined 28e. Pla	ce of Injury - At Iding, etc. (Spe	nome, tarm, st cify)	reet, factory, office		28f. Location City or To	(Street ar own, State	na Number e)	or Hura	I Houte Nurr	iber,
Division	within 24 hours a To the Funeral C		CO. CHE.	- Physician T- 1	- A		h		and dun to the		\ d			
3	Fun Fun fely f	Medical		Examiner: On the	basis of exami		th occurred at the time extigation, in my op-							s)
c de c	within 24 h To the Fur	Med	29b. Signature and hitle of certifie	111	inher stated.		29c. License	e number		29d. Da	ate signed ((Month.	Dav. Year)	
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	70		- Or conv	JUV	VVCov	700	0.1.0							
			30. Name and address of person				Print) Glen Road	#200	Silva~	Snri	no n	יכ חז	1910	ļ
3382		ate	Alan I. Kermai 31. Date filed (Month, Day, Year,	32.	Registrar's Sig	nature	1 11.	η πΖΟΟ,	PITAGE	PhrT	ny, r.	1U Z	- TO	
3	Sta Regist	ate rar		1 2006	Elevis	J. A	Jacobi							

			1 - For State Registrar		aryland / Depa	artmer	nt of H		nd Me	ental Hy	Reg. No.2	006	16684
П	Physici		Decedent's Name (First, Middle, La Rudi	Ernesto	DeLe	on				2. Date of De Month May	10, ^{Day} 20	06 ^{Year}	3. Time of Death 1:23a M
	/Medic Examin		4a. Facility Name (If not institution, given Casey House	e street and number)		4b. City	Town, or	Location of ille	Death		4c. Cou	inty of Death	
	Funeral Director		5. Social Security Number 6. S none Usual Residence of Decedent	ex 7. Age X∑M 2□F	e (In yrs. last birthday) 35 Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da 11/07	th ay, Year) /1970	Cou	place (State or Foreign ntry) temala
	e Maryland 3a-f show tillied at	ctor	10a. State 10b. County MD Montgo	omery	10c. City, Town or Lo Germa		vn						10d. Inside City Limits 1 ☐ Yes 2X No
	h with th	ai Dire	10e. Street and Number 11461 Apple D	owre Way			Code 2087	6			10g. Citizen	of What Cou Luaten	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show important: If Item 27 is marked other then "half a hour and item from the motified at an once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	10	Was Dece f Yes, spe 1 Yes	cify Cubai	spanic Origi n, Mexican, Specify: Guat	Puerto R	_	'	Race - Ameri Black, White, ecify:	
21215-0036	d within 72 hogiene.	completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5	(dent's Usu kind of wo DO NOT u	ork done d ise retired,	ition luring most (of workin	g		one	ndustry
Maryland	should be filed and Mental Hygi marked other umatic event, III	To Be (17. Father's Name (First, Middle, Last) Maximilliano	DeLeon				Jesu	ıs L	opez	, Maiden Sun		
	and 2 shualth and 27 is m		19a. Informant's Name/Relationship (Blanca Estela/		19b. Mailir 1146	ng Addres	s (Street a	nd Number Dowr	or Rural	ay Ge	er, City or To rmant	wn, State, Zij OWN , N	1d 20876
Baltimore,	t. Pages 1 artment of He rtant: If Item		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 2 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	()	20b. Place of Dispo cemetery, crer Municip	al (cther place cem.	5/1	Da 16/0	6	Quet Guat	emala	enango,
Bal	permit. Departr Importa eny inj		21. Signature of Funeral Service Con-	2'	PÎ 9 2	11111 141 (od Addres Colu	RTNAY mbia	DI Blv	FUNER d.Sil	AL SE	RVICE	E,P.A. g,Md20910
1	Fnysician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heak failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lir a. End sta	the death. Do not ent le. age humar a consequence of):					•		ie	Approximate Interval Between Onset and Death Years
68760,	te be executed ysician end e burial-transit	ical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):								
P.O. Box 68	The law requires that the death certificate be executed tie hes been signed by the attending physician end bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic p						Date of delive	ery Day Year
	quires that on signed build be deta	þ	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the u	nderlying (ause give	n in Part I.			obacco use c Yes 2½∑No		he cause of death?
al Records,	ician: The law requir certificate hes been si rector, page 2 should	Completed							_	24a. Was autop perfo 1 Yes	osy ormed?	b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of 2 No
f Vital	S D	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatien	t 3 DC	Othe			Check only o	_	Other (Specif	hospice
Division of	ding h. After fune		27. Manner of Death 1 Matural 5 Pending 2 Accident investigation		y 28b. Time of Year) Injury	M	28c. Injury Work 1 🗆 Y		28		how injury occ		
Divis	or To the Mospital or Attend within 24 hours after death To the Funsral Director; completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ury - At home, farm, str. (Specify)	eet, factor	y, office		28	If. Location (S City or Tox		mber or Rura	l Route Number,
	Hospi 24 hou Funsi e Funsi etely fil	Medical	29a. Certifier 1 A Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	of my knowledge, death examination and/or invited.	occurred estigation	at the time , in my op	e, date and inion, death	place, an	d due to the d at the time,	cause(s) and date and plac	manner as s e, and due to	tated. the cause(s)
)	Within To th	Me	29b. Signature and title of certifier			29	D42	number 2452			29d. Date sig May	10,2	
			30. Name and address er who Chitra Rajagopa		01 Munca	stre		.l Rd	Roc	ckvill	le,Md	20850)
	Sta Registr	_	31. Date filed (Month, Day, Year) MAY 1 1 2	32. Registra	n's Signature	neft!							

		1 - For State Ragistrar	State	of Marylan	nd / Depa <i>Cei</i>	artment rtificate	of H	ealth a Death	ınd Me		iene	2006	16685
Discount 1		1. Decedent's Name (First, Middle	, Last)					-	:	2. Date of Dear Month	h Day	Year	3. Time of Death
Physicia /Medic		William		Harper		Da	vis,	Sr.		May 11		006	11:30 A M
Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, T	Town, or	Location of	f Death		4c.	County of De	
		126 South St	reet					erlan				Alleg.	any
Funeral		5. Social Security Number	6. Sex 11∕ M 2 F	7. Age (In yrs.	**	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day)	Year)	9. B	rthplace (State or Foreign
Director		214-30-9734)A) M 20 F	7.2	Yrs.					02/11/1			ryland
pu *	ŀ	Usual Residence of Decedent 10a, State 10b, County		10c Cit	ly, Town or Lo	cation							10d. Inside City Limits
anyli eho	ក		egany			Cumbe	rlan	d					1 ☑ Yes 2 ☐ No
The N	Director	10e. Street and Number	egany					·u			0- 0'1		**
filed within 72 hours after deeth with the Maryland Hygiene. Hygiene 14 hour sther then "naturel; or items 23s or 28s-f show out, the Medical Examinat must be notified at						10f. Zip				'		zen of What C	ountry?
e 23	Funeral	126 South		cedent Ever in U	C 121	Mas Dasad	215		nia 2 / Cana	W. Vac as No		ISA 14. Race - Am	andana la dina
item item	E I	11. Marital Status 1 □ Never Married 2 ☑ Marr	Armed F	orces?	.5.	f Yes, speci	fy Cubar	n, Mexican,	, Puerto R	ify Yes or No- ican, etc.)		Black, Wh	
irs af	by	3 ☐ Widowed 4 ☐ Divorced	H Vec C	live Dates:	i i	1□Yes 2	No No	Specify:				Specify:	h:+-
2 hou	ed	15. Deceden	t's Education	No.MI	16a. Dece	dent's Usual	Occupa	tion		-	16b. Ki	nd of Busines	hite
nn 7	Completed	(Specify only highes			(Give	kind of worl DO NOT use	k done di e retired)	uring most	of working	g			
rthe end	E	Elementary/Secondary (0-12) 10	College	(1-4or 5+)	Ma	inten	ance	1			Р	ublic	Schools
other t	Bec	17. Father's Name (First, Middle,	Last)				1		r's Name	(First, Middle, I			
should be and Mental marked c	ToB	Harry		Davis	5			Stel	11a			F	ord
short Name		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street a	nd Number	r or Aural	Route Number	, City o	r Town, State,	Zip Code)
and 2 eelth a n 27 is		Patricia A. Da	vis / wi	fe	126	South	Str	eet,	Cumb	erland,	MD	2150	2
oth oth		20a. Method of Disposition			Place of Dispo	sition (Nam	e of her place	,)	Da	ite	20c. Lo	cation - City o	r Town, State
Pages nent of t int: If its		1 XBurial 2 ☐ Cremation 4 ☐ Donation _ 5 ☐ Other (S		n State	-			· 1	05/	15/2006		LaVale.	, MD
교육원을 .		21. Signature of Funeral Service	Licensee							the second second second			l Home, P.A.
Depermine Deperm		talt C	Holm	- 1	4	04 Dec	catu	r Str	eet,	Cumber	lan	d, MD	21502
	Taction in	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	each line.	h. Do not ent	er the mode	of dying	, such as o	cardiac or	respiratory arre	est,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a A	spiratio	n Pneu	monia							Onset and Death
/Medical Examiner		resulting in death)		o (or as a conseq						·			
LAdminer	_	Sequentially list conditions,		ementia						_			
sit sd	Examiner	Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a consuc	manna of):								
and I-tran	хап	that initiated events resulting in death) Last	c. Due to	o (or as a conseq	wanna of):								
be executed sicien and burial-transit	E			(0, 20 2 00,1300	1001100 017.								
physics the t	dical		d										
The law requires that the death certificate be executed steep that the death certificate be executed at has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE:	23c If yes o	utcome of pregna	ancy								
etten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	ıl death 3□	Ectopic pre					2	23d. Date of de Month	Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk	nant at time of d	eatn 5L	Other (spe	есту)						•
that the de led by the c		Part II. Other significant condition	ns contributing to	death but not res	ulting in the u	nderlving ca	usa diva	n in Part I		23e. Did tot	acco u	se contribute :	to the cause of death?
signed d be del	d b		s Mellitu				g	THE COLUMN			s 25	_	Probably 4 Unknown
w requir been s should	ete	Diabete	S IICITICE							-		A	
has l	Completed									24a. Was a autops	y	prior to	utopsy findings available completion of cause of
: The cete ha	S									perform 1 ☐ Yes 2		death?	
sicien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hoenital:				100.		of Death	Check only on	e/		
Phys this	2	1 Yes 2 No	11	Inpatient 2				4 🗀 Nur		e 5X Reside			ecify)
tending Physicien: leeth. tor: After this certific the funeral director.	- Lo	27. Manner of Death 1 ☑ Naturat 5 ☐ Pendin	g (Mo	e of Injury nth, Day Year)	28b. Time of Injury		Sc. Injury Work		- 1	3d. Describe ho	w injury	occurred	
the start	cat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be as Bloc	na of faire. At h		М		es 2□N		26 1		111	
or At of At of At or At or At or At	Certification;	4 Homicide determ	ined 200. Place	e of fnjury - At hi ding, etc. (Specif	ome, tarm, str fy)	eet, factory,	office		28	City or Town	. State	Number or F	iural Route Number,
pital ours e orei		29a. Certifier 1♥ Certifyin	o Physicians To "	a bast of cont	andodas da ::		A 86 - 11	- dc+:	d mla si				
To the Hospital or Attending Physicien: within 24 hours elter death To the Funerel Director: After this certifica completely filled in by the funeral director.	edicai	(Check only 2 Medical one)	g Physician: To the Examiner: On the and ma	te best of my kno basis of examina nner stated.	wieuge, death	vestigation,	in my op	e, date and inion, death	piace, ar h occurred	d at the time, do	use(s) ate and	and manner a place, and du	is stated. e to the cause(s)
vithin of th	Me	29b. Signature and title of certifie				29c.	License	number		2	9d. Date	e signed (Mor	oth, Day, Year)
96		>	Bla 1	20			D175	65			May	11, 2	006
5,		30. Name and address of person			n 23a) (Type	Print)							
2			J. Boll				2 Na	tiona	al Hi	ghway,	LaV	ale. M	D 21502
Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ature				_ **±	0		II	
Registr	ar	MAY 1	2 2006	Merca	J.	Good	1						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Billv Davis 1314 P M 13, 2006 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 824 Shawnee Avenue Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1♥M 2□F 67 Yrs. Director 215-34-4302 01/03/1939 Illinois Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be nutified at 1 X Yes 2 □ No Director MD Cumberland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a or 824 Shawnee Avenue 21502 USA deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced "natural". White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. snt: If item 27 ie marked other then ' ury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Tire and Rubber 11 Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rachae1 Elmer Eugene Jane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9202 Heather Field Court, Laytonsville, MD Connie J. Davis / daughter 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Depertment of Important: If eny injury or once. Cumberland Crematory 05/15/2006 Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD all 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op-gach line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No after death.

Director: After this certification by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 Tes 2 No 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel [Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) ŧ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054411 May 15, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., Beverly Calkins, 500 Memorial Avenue, Cumberland, MD 32. Registar's Signature 31. Date filed (Month, Day, Year) State MAY 1 5 2006 Registrar

			1 - For State Registrar		State of Ma	aryland / I			t of Healti e <i>of Deal</i>		nental Hy	giene Reg. No	2000	16687
			Decedent's Name	(First, Middle, Las	it)						2. Date of De	eath		3. Time of Death
	Physicia		He1	Len	C	arroll		Т	Dailev		Month	7. 2	ay Year 2006	11:55 A ^M
	/Medic		4a. Facility Name (If	not institution, give	street and number)				Town, or Location	on of Death	124		c. County of Deat	
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	Funeral		5. Social Security Nu		9x 7. Age □ M 2 X F	e (In yrs. last bi		If Under Months	1 Year If Und Days Hour		8. Date of Bi (Month, D	rth a <i>y</i> , Ye <i>ar</i>	9. Birtl	nplace (State or Foreign untry)
	Director		212-38-5 Usual Residence of D	195		65	Yrs.				05/15/	194	0 Mar	yland
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r dea	er m	Iner	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S.	13. V	Vas Deced f Yes, spec	lent of Hispanic of Cuban, Mexi	Origin? (Sp	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White	
s afte	무를	by Funeral Director	1 Never Marrie 3 Widowed 4		1 ☐ Yes 2 ☐XN If Yes, Give	40		I□Yes 2					Specify:	
3 3	fure!			15. Decedent's Ed	Year or Dates:	162	Deced	lant's Heura	Il Occupation		_	16b k	Kind of Business/	White
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N N	i the	E	Elementary/Secon 12	dary (0-12)	College (1-4or 5	1+)		Nurse	e				Hospital	
d be file	al Hyg	Bec	17. Father's Name (F	First, Middle, Last)						other's Nam	e (First, Middle			
old b	Ment arked	2	Harry	Law	rence	0	'Rou	ırke	1	Anna	P	auli	ne	Tucci
2 sho	and is my		19a. Informant's Nar	me/Relationship (Гурө, Print)	198	o. Mailin	g Address	(Street and Nu	mber or Rur	al Route Numb	er, City	or Town, State, Z	ip Code)
and s	of Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-1 show other traumatic event, I'm Medical Examinal must be notified at		M. Josep	oh Dailey	Jr. / h	usband	246	13 21	lst Bri	dge Ri	Date SW	., R	awlings,	MD 21557
Ses	or of		1 🗆 Burial 2 🔯	Cremation 3	Removal from State	1	гу, сгеп	natory or of	ther place)				ocation - City or	
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D ed	Depertment of Healt Important: if Item 2' eny injury or other!		21. Signaturo di Pun	T C	A.Q.	- ^			ecatur :					21502
			23a. Part1. Enter the	e disease, or com	plications that caused one cause on each ly	the death. Do	not ente	er the mode	e of dying, such	as cardiac	or respiratory a	arrest,		Approximate Interval Between
Ph	ysician		Immediate Cause (F	inal	Metas	tatic	10	dies	ast Ca	MCer				Onset and Death
/0	Medical		resulting in death)		Due to (or as	a consequence	of):							reco je su.
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pel	sit	- Ju	if any, leading to imr cause. Enter Under Cause (Disease or in	mediate tying niury	Due to (or as	a consequence	of):							
, axecu	al-tra/	Examiner	that initiated events resulting in death) La		C. Due to (or as	a consequence	of):							
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riffica	ng ph as th	Med	IF FEMALE:											
ath ce	ttendi or use	an/	23b. Was decedent in the past 12 n		23c. If yes, outcome 1☐Live birth	2 Fetal death		Ectopic pre				T	23d. Date of deli	very Day Year
) e	the a	Physician/M	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant at 9□Unknown	time of death	5 🗆	Other (spe	ecify)				MONIT	Day real
thet t	ed by detac	P.		cant conditions o	ontributing to death be	ut not resulting	in the un	nderlying ca	ause given in Pa	art I.	23e. Did	tobacco	use contribute to	the cause of death?
cords, w requires t	been signed by the attending should be detached for use a	d by	4.4	indeen				, ,			1 🗆	Yes 2	No 3□Pro	obably 4 Unknown
5 ×	shou	lete		1							24a. Was	an	24h Were au	topsy findings available
F 5	age 2	Completed										ormed?	prior to o	ompletion of cause of
Vilal Iclan:	rtifice tor, p	0	25. Was case referre	ed to medical					26. PI	lace of Deat	1 ☐ Yes	one)	o 1 ☐ Yes	2006
ysic V	nis ce direc	To B	examiner? 1 ☐ Yes 2 7 1	No	Hospital: 1 X Inpatie	int 2□ER/Oi	utpatient	t 3 DO	04				6 □Other (Spec	ufy)
2 g 4 g	fter th		27. Manner of Death 1 ☑Natural	5 Pending	28a. Date of Injur (Month, Da)		Time of Injury	21	8c. Injury at Work?		28d. Describe			
tend in	leath.	cati	2 ☐ Accident 3 ☐ Suicide	investigation				М	1 Yes 2	2 □ No				
UNISION I or Attending	efter of Direct	Certification:	4 Homicide	determined	28e. Place of Inju- building, etc	ury - At home, fa c. <i>(Specify)</i>	arm, stre	eet, factory	, office		28f. Location (City or To	(Street a wn, Stat	nd Number or Ru 'e)	ral Route Number,
lospite	within 24 hours effer death. To the Funerel Director: Affer this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only	1⊠ Certifying Ph	ysician: To the best of	of my knowledg	e, death	occurred a	at the time, date	and place,	and due to the	cause(s	s) and manner as	stated.
the t	thin 24 of the F amplete	Med	one) 29b. Signature and t		and manner sta	ited.			. License numb		iod at the time.		ate signed (Month	
Ĕ	<u>₹</u>) A	ma a	in mo									
	125		30. Name and addre	ss of person who	completed cause of d		(Type, I)46346			j	May 8, 2	006
11	120		Hu	ıma Shaki	1, M.D.,	625 Ker	nt A	venue	e, Cumbe	erland	, MD 2	2150	2	
	Sta Registr		31. Date filed (Mont)	n, Day, Year) MAY 092	32. Refistra	ar's Signature	19	perk	,					

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 4:20 PM DAVIS 2006 NANNIE 11 May /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WORCESTER BERLIN NURSING & REHABILITATION CTR. BERLIN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. JAN. 31, 1912 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months VIRGINIA Yrs 94 219-56-8765 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County **ehow** other than "naturel", or iteme 23e or 28a-f ehovent, the Medical Examiner must be notified at 1X Yes 2 ☐ No BERLIN Directo MARYLAND WORCESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **UNIT 112** 21811 USA 1 MEADOW STREET Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Avis, Nannie Ilmore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 12 permit Pages 1 and 2 should be fit.
Department of Health and Mental Hy Importent: if Item 27 is marked other any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **MEARS** ELIZABETH ARTHUR KELLAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 118 CEDAR AVE., BERLIN, MARYLAND 21811 MILDRED ANN VILLANI/EXECUTOR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State CREMATORY OF DELMARVA 5/12/06 DELMAR, DELAWARE 5 Other (Specify) 22. Name and Address of Facility 21. Signature HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Theosoleane ardiovascular **Physician** cers /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. Completed by Physician/Medical the the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 ☐ Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2500 certificete 1 ☐ Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 Yes \$₹ No Nursing Home 5 Residence 6 Other (Specify) Certification: To nerei Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funerei C ro the Hospital Certifying Physician: To the best of my knowledge, death postimed at the time, date and place, and due to the cause(s) and manner as stated 23s. Cartifor Certifying Physician: To the best of my knowledge death occurred at the time date and piece and to the date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signayareyan title of edifier who completed cause of death (Item 23a) (Type, Print) A Coartal Hague MOGO elca 31. Date filed (Month, Day, Year) MAY 12 32. Sgistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2006 Frances Effie Compson May 3:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14114 Howdyshell Road, NEFlintstone Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Min. 1 ☐ M 2 🖾 F Yrs. Director 92 England 213-64-2376 09/16/1913 Usual Residence of Decedent within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or Iteme 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Allegany Flintstone 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? 14114 Howdyshell Road, NE 21530 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify ģ 3 XWidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) 12 Registered Nurse Hospital other permit. Peges 1 and 2 should be filk Department of Health and Mental Hy Important: if Item 27 I e marked otheny injury or other treumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard Henry Frederick Grieson Catherine Hawes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gillian F. Smith / daughter 14114 Howdyshell Road, NE., Flintstone, MD 21530 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Cumberland Crematory 05/08/2006 4 Donation 5 Other (Specify) Cumberland, MD 21. Signature of Fur ral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, alux 404 Decatur Street, Cumberland, MD Part 1. Enter the disease, or complications that cause of he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEHYDRATION /Medical Due to (or as a consequence of): Examiner HTN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the ettending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown es been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 HYPERLIPIDEMIA 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed GLAUCOMA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? hes autopsy performed this certificate OA 1□ Yes 2□ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one. Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner death 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending deeth. investigation 1 ☐ Yes 2 ☐ No completely filled in by the 2 Accident efter deeth 6 Could not be determined 3 ☐ Suicide 28e. Place of friury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical e of certifies 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year) M.D. D59121 0 May 8, 2006 Rei 30 Name and address of person who completed cause of death (ftem 23a) (Type, Print) 625 Kent Avenue, Cumberland, Maryland Tasneem Malik, M.D., 32. Pojistrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 0 8 2006

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Douglas Arthur Elmendorf Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

		For State	State of Ma	arylan		irtment of H		Mental Hygie	7000	16690
s III e a		Registrar 1. Decedent's Name (First, Middle, Last)				imouto or i	JOUIT	Reg.	NO.	3. Time of Death
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/Medic Examin	2	4a. Facility Name (If not institution, give s				4b. City, Town, or	Location of Death	1	4c. County of Dea	
Examin	er	Doctor's Community		1		Lanham		į.	rince Geo	
Funeral	(C)	5. Social Security Number 6. Sex	7. Ag		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign
Director		213-42-7802	【M 2□F	62	Yrs.	Months Days	Hours Min.	09/17/19	43 Mary	yland
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anylar ahow dat	_	10a. State 10b. County			y, Town or Lo	cation				10d. Inside City Limits
Ba-f	Director	Maryland Anne Aru	ndel	Harv	vood					1 □ Yes 2√XNo
with th	Dire	10e. Street and Number				10f. Zip Code			. Citizen of What Co	ountry?
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and and sum		19a. Informant's Name/Relationship (Ty			19b. Mailin	g Address (Street a	and Number or Ru	ral Route Number, C	ity or Town, State, .	Zip Code)
and ealth m 27	1 3	Anna Marie Elmendo	orf/ Wife					rwood, MD		
Tof H		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ P	lemoval from State	20b. P	lace of Dispo: emetery, cren	sition (Name of natory or other plac	θ)	Date 200	c. Location - City or	Town, State
Pa tant: jury		4 ☐ Donation 5 ☐ Other (Specify)		Hur		ematory		0/2006 Wa		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Important: If from 27 is marked other than "naturat", or itama 23a or 28a-1 ahow any injury or other traumatic avent, the Madical Examinar must be notified at once.		21. Signature of Funeral Service License	**					pert E. Ev ad Bowie,		ral Home
		23a. Part1. Enter the disease, or compli	cations that caused	the deat	-		•			Approximate
Physician		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each ii	ne. Ra À	01/10	1	g can	DAD		Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as	a conseq	uence of):	$\sim uv$	y arro	CVIC		011011774
Examiner				·						
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ie exe		resulting in death) cast	Due to (or as	a conseq	uence of):					
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The law requires that the death certificate be executed the has been signed by the attanding physicien and bage 2 should be detached for use as the burial-transli	/Me	IF FEMALE:	2a If was autooma	of account						
attand for us	ician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 Live birth	2 Feta	Ideath 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
the de	hysic	1 □ Yes 2 □ No 9 □ Unknown	4∏Pregnant at 9∏Unknown	t time of a	eath 5L	Other (specify)				Í
that the ded by the	<u>a</u>	Part II. Other significant conditions cor	ntributing to death b	ut not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
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	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:		5D/0	Othe	arr	th (Check only one)		
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To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.		29a. Certifier Certifying Physical Exami	sician: To the best	of my kno	wledge, death	occurred at the tin	ne, date and place,	and due to the caus	e(s) and manner as	s stated.
tha Ho nin 24 tha Fu nplete	edical	one)	and manner st	ated.	tion and/or inv	restigation, in my of	oinion, death occui	rred at the time, date	and place, and due	to the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of postifier	112			29c. License	number	29d.	Date signed (Mont	h, Day, Year)
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		30. Name and address of person who co	ompleted cause of c	death (Iten	п 23а) (Туре,	Print) 620/	arrive.	NBELTO	CAD, C	1#3
3-12 - C		31. Date filed (Month, Day, Year)	B Registr	ar's Signa	iture	COKKE	K PARK	mo d	0740	
Sta Registr		MAY 1 0 2000		ui s signa	ha	A 0				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11:05 PM May 18, 2006 Robert M. Fairbank /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millennium at Marley Neck Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Months Director 6-2-1926 Maryland 212-20-8180 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or Itema 23a or 28a-f show traumatic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 X No Director Annapolis Maryland | Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21401 USA 906 Boom Way by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filled within 72 hours after in nent of Health and Mental Hygiene. ant: if itsm 27 is marked other then "natursi", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White Year or Dates:W.W. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Oil 2 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Fairbank Mae Lindsay ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth S. Fairbank/ Wife 906 Boom Way, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Important: if eny injury or 5-20-06 Kalas Crematory Edgewater, MD 21. Signatur of Funeral ervice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Celliac disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner)enelia Sequentially list cano ions if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ettending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760, pe q Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 4 Pregnant at time of death P.0. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Ninknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ို 2 ER/Outpatient 3 DOA lhis 28c. Injury Work 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30, Name and addre of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

6 2006

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) ^{Day} 2006 Year **Physician** Robert 10, Farlow May 1:35 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Salisbury 612 Douglas Road Wicomico Date of Birth (Month, Day, Yea, 8/2/1921 If Under 1 Year Months Days Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Hours 1 XM 2 ☐ F 84 New Jersey 137-18-7137 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Maryland Wicomico Salisbury Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 612 Douglas Road 21801 USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

↑ Yes 2 No 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Navy Specify: white Completed by 3 Novidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesman Electrical Supply 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert H. Farlow Grace MacPherson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bob Farlow/son PO Box 104, Allen, MD 21810 20b. Place of Disposition (Name of cometery, crematory or other place).
WICOMICO MEMORIAL 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/15/06 Salisbury, MD · 4 □Donation 5X□Other (Specify) Entombment Park 2. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Peny 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition newwa. resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b Due to (or as a consequence of) Examiner Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Year in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed) 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes / 2 No 1 Inpatient 3 DOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: Injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

within 24 hours after death. To the Funeral Director: A filled in by the To the Hospital completely

Funeral

Director

ral', or itema 23a or 28a-f show Examiner must be notified at

"natural", or itema 23a

item 27 is marked other then "natur other treumatic event, the Medical

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any injury or other treumatic event, 90x8:

Physician

Examiner

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

/Medical

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Physicien:

or Attending

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

8



29c. License number

619

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29d. Date signed (Month, Day, Year)

	1 _ For	State of Maryland		irtment of H <i>tificate of L</i>			iene2 () () ()	16693
	Registrar 1. Decedent's Name (First, Middle, Last)		inouto or E		2. Date of Deat	th	3. Time of Death
Physician /Medical	ARTHUR	DANIEL		FLEMIN		MAY MAY	11, 2006	9:05 A M
Examiner	4a. Facility Name (If not institution, give			-	Location of Death		4c. County of Dea	
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Funeral Director	5. Social Security Number 6. Se 212-24-4554	7 aDe	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, March 2	Year) 9. Bi 1,1928 Ma	rthplace (State or Foreign ountry) ryland
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2 should I and Meni ie marke ie marke To	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailin	g Address (Street a	and Number or Ru	ral Route Number	, City or Town, State,	Zip Code)
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34/11/	30. Name and address of person who	impleted cause of death (Item 2	3a) (Type,	TOROK	touse	Ave F	5-11- Frederic	el MD
State Registrar	31. Date filed (Month, Day, Year) MAY 12 2	006 32. egistrar's Signatur	& A	parte				21701

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	Funeral Director			one)	Sex M∑M 2□F	7. Age (In yrs	last birthday) 84 Yrs.	If Under 1 Months [Hours	Min.	B. Date of Birt (Month, Day Oct 26,	y, Year) 192	9. Bir C Per	thplace (State or buntry)	Foreign
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item#23e 5/19/08 fate of Maryland / Department of Health and Mental Hygiene For State State Co. Health rjw Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** JAMES H. GAMBILL, JR 10 16:45 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ELKTON
If Under 1 Year If Under 24 Hrs. CECIL LAURELWOOD CARE CENTER 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Hours 1**X**M 2□ F Months Davs Yrs Director JANJARY 16,1926 220-12-6804 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Exercitive must be notified at 1X Yes 2 □ No Directo MARYLAND RISING SUN CECIL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "--- any injury or other traumer's once. 5 Items 23a UNITED STATES 100 MCNAMEE LANE, AFT. 211 21911 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. NY Yes 2 WORLD WAR 1 ☐ Yes 2 No Specify: 1 Never Married 2 Married Specify: WHITE 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 MEAT CUTTER/MANAGER GROCERY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **ENVA GUALTNEY** JAMES H. GAMBILL ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY TURNER/DAUGHTER 241 WILLARD DRIVE, NORTH EAST, MARYLAND 21901 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State LITTLE BRITAIN CEMETERY MAY 15,2006 LITTLE BRITAIN, FA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R.T. FOARD FUNERAL HOME, P.A. 111 S. QUEEN ST., RISING SUN, MD 21911 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastrointestinal bleed **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: P.O. Box 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Dther (specify) 9 Unknown 5 cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by -- 1 2 2 2 5 − 2 □ No 3 ☐ Probably 4 ☐Unknown 24a. Was an autopsy performed?

1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital 29a. Certifier (s) certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ê. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie May 12, 2006 57 address of person who completed cause of death (Item 23a) (Type, Print) Seasons Horkas, 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 74. **Physician** 2006 009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis Anne Arundel Anne Arundel Medical Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Months Days Hours 1 ☐ M 25 F 88 5, Summitt, 1917 192-12-0022 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 le marked other then "naturel", or thems 23a or 28a-f ehow any injury or other traumatic event, it is Mardical Examinar must be published at once. XXYes 2 □ No Anne Arundel Crofton Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21114 **USA** 1716 Mayfair Place Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 10th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Christina Elizabeth Fetzer Joseph Graham 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Crofton, MD 21114 Lois Woelfel 1716 Mayfair Place 20b. Place of Disposition (Name of competery, crematory or other place)
Stanly Gardens of Memory 5-19-06 Albermarle, NC 20c. Location - City or Town, State 20a Method of Disposition 1√ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BEALL Funeral Home 21. Signature of Funeral Service Licenses 6512 NW Crain Hwy. Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZLecks **Physician** Oneuminia disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to intrindiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed 0154-Due to (or as a consequen of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an certificate has 1 Yes 2 1 No 1 Yes 2 3 NO or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To After thi funeral 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Not WISTE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Gronne-12 2 (adiys 05 /Medical 2006 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Salis lowry

If Under 1 Year | If Under 24 Hrs.

Days | Hours | Min. Nursing and Rehabilitation 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2X F 324-38-3415 96 Director 1/14/1910 Illinois Usuel Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at Maryland Wicomico Salisbury 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Times Square 21801 USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after the Hygiene. Meterally or the theory or the theory and the theory or the 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: β If Yes, Give Year or Dates: Specify: white 3 DWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher 12 Public Education permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If Item 27 is marked other any injury or other traumatic event, It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be A. Harrison Hull Sophia Koch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev.Dr. Lawrence H. Stookey/son PO Box 111, Allen, MD 21810 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Valhalla Mausoleum 5/16/06 Belleville, IL 4 □Donation 5 ②Cother (Specify) Entombment 21. Signature of Funeral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Heatt M CESP pueu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DEMENTIA disease or condition 10 4 cons resulting in death) /Medical Due to (or as a consequence of) Examiner 154 cars AS CVI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician P.O. Box 68760 Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Year Dav 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 should be 4. Unknown 1 ☐ Yes 2 🗆 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

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				MAY 1 9 200	2. Re	gistrar's Signa	ture (pe	de la								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year MAY 2006 22, 8:20 A. M ELMER THOMAS GOLDHAMMER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8 WAYCROSS CT. **EMMITSBURG** FREDERICK | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | AUG. 8, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F 87 Director 212-07-4224 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Director MD FREDERICK EMMITSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Items 23a 8 WAYCROSS CT. 21727 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or item any injury or other treumatic event, I're Modical Examinal. once. Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3 PLUMBER PLUMBING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) THOMAS JEFFERSON GOLDHAMMER BESSIE TALBERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN HARPSTER/DAUGHTER 8 WAYCROSS CT., EMMITSBURG, MD 21727 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) SMITHSBURG CREMATORIUM 5/23/06 SMITHSBURG, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME Reles 210 W. MAIN ST., EMMITSBURG, MD. 21727-0427 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final A Thenosclentic Candio Vascula **Physician** 30411 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (c) as a consequence of) Examine law requires that the death certificate be executed attending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performed? Division of Vital 1 Yes 1 Yes 2 No 2 X No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t Certification; 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1反 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 120035152 MAY 23, 2006 30. Name and widress of person who completed cause of death (Item 23a) (Type, Print) 100 S. Censen MD Krim 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

		1	For State Registrar	State of M	arylan		rtment of H tificate of I	lealth and M Death		giene Reg. No.	06	16700
	/siciai ledica	n	1. Decedent's Name (First, Middle, L William E. Gat						2. Date of Dea Month May 8	Day	Year	3. Time of Death 5:50 P
	amine eral	r		Sex 7. A(last birthday) Yrs.	Annapo Il Under 1 Year Months Days	r Location of Death Olis If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 6–17–	Anne Anne	9. Birthi	
7			Usual Residence of Decedent 10a, State 10b, County		10c. City	/, Town or Lo			0-17-	1930		10d. Inside City Limits 1 ☐ Yes 2 🕅 No
with the M	it be notifie	Direc	Maryland Anne Ard 10e. Street and Number 331 Beach Driv		1	Annapo	10f. Zip Code	21403		10g. Citizen of W USA	Vhat Cou	
5-0036 72 hours after death with the Maryland maturel; or Items 23e or 28e-f show	Examiner mu	by rur	11. Marital Status 1 Never Married 2 (X Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 N If Yes, Give Year or Dates:	?	1	□Yes 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Specify	k, White, Wh	nite
21215-0036 ad within 72 hours atter gliene.	La Medica	Completed	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12) 8th	rade completed) College (1-4or	5+)	(Give life. L	ent's Usual Occup kind of work done o DO NOT use retired penter	during most of work		D.C. GC	vern	
ryland rould be file 1 Mental Hy	natic svan	lo Be	17. Father's Name (First, Middle, Las William Harry 19a. Informant's Name/Relationship	Gateau		10h 34=://-	a Address (Chr.		R. Culv	er		a Cadal
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or leams 23e or 28a-1 show	y or other traun		Joan G. Gateau/ 20a. Method of Disposition 12Burial 2 Cremation 3 4 Oponation 5 Other (Spec	Mife □Removal from State		331 lace of Dispo		ce)	∞ lis, I		City or T	own, State
Baltir permit. P Departme Importan	eny Injur		21. Signature it uneral service Lice	••	100.	22	. Name and Addre	ss of Facility Ger	orge P.	Kalas F	uner	cal Home
Physic /Medi Exami	ical		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	mplications that cause y one cause on each a Due to (or a	line.	Nel	er the mode of dyin	•	or respiratory ai	rrest,		Approximate Interval Between Onset and Death
8760, rate be executed hysician and	the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as d. d.								,,(0
Vision of Vital Records, P.O. Box 6 Attanding Physician: The law requires that the death certific reach.	ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fete	I death 3	Ectopic pregnancy Other (specify)	/		23d. Date Mor		rery Day Year
ords, P equires that en signed t	tep ed pinc	<u>م</u>	Part II. Other significant conditions	contributing to death	but not res	ulting in the ur	nderlying cause giv	en in Part I.				the cause of death? bably 4 □Unknown
al Recc : The law racate has be	, page 2 sh	Completed							24a. Was autor perio 1 ☐ Yes	rmed? d	leath?	opsy lindings available ompletion of cause of 2 No
on of Vital F ding Physician: Th n. Atter this certificate	<u> </u>	n: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpat		ER/Outpatien 28b. Time of Injury		4 Nursing Ho	me 5 Resid	one) dence 6 □Othe how injury occurr		fy)
Division of Vital Records, To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signe	in by the fur	Certification:	1 🖾 Natural 5 ☐ Pending investigati 3 ☐ Suicide 4 ☐ Homicide	be 28e. Place of Ir		ome, larm, str		Yes 2 □No	28l. Location (Street and Number vn, State)	er or Rur	ral Route Number,
ve Hospital	oletely filled	Medical C	29a. Certifier (Check only one)	Physician: To the bes aminer: On the basis and manner s	of examina	wledge, death tion and/or inv	n occurred at the tir vestigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and ma date and place, a	nner as s and due t	stated. to the cause(s)
To the Within To the	duoo	M	29b. Signature and title of certifier	BM	1 11	D	29c. Licens	5 (3 0)		29d. Date signed	(Month,	Day, Year)
			30. Name and address of person where the state of the sta	AMD G	death (Item	BOTH	Print) PD	#300	Ann	go lis 1	MO	21401
Re	Stat gistra	-	MAY 1 0 2		a. Joigile	k do	والم					

			1 - For State Registrar	State of N	larylan		artment rtificate			and M		giene Reg. No.	00	6	167	0
	Dharaini		1. Decedent's Name (First, Midd	lle, Last)							2. Date of De Month	ath Day		ear (3. Time of	Death
	Physici /Medi		Jacqueline		1	Hughes					May	14	20		6:55	P M
	Examir		4a. Facility Name (If not institution	on, give street and numbe	r)		4b. City, T	own, or	Location o	f Death		4c. 0	County of	Death		
н			St. Catherine'		enter			itsb					Free			
	Funeral		5. Social Security Number	6. Sex 7. A		last birthday)		Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	\$	Birthp	place (State o	r Foreign
	Director		578-40-4522	ICINI ZWIF	90	Yrs.					July 1	8, 19	15	Fra	nce	
	and *		Usual Residence of Decedent 10a. State 10b. County	/	10c. Cit	y, Town or Lo	cation								0d. Inside Cit	ty Limits
	fanyli sho	5													1 ☐ Yes	-
	28a-1	Director	Maryland Fred	erick			ville	ando.				10g. Citiz		-1 C		
	with	٥		11 D 1			101. 210		- 1						-	
	eath	by Funeral	3602 Green Va	12. Was Deceder	t Ever in II	S 13 1	Was Decede	217		nin? (Sne	acifu Ves or No	Unit			es an Indian,	
	ter d	L.	1 Never Married 2 Mai	Armed Forces	?		f Yes, specif	y Cubar	n, Mexican,	Puerto	ecify Yes or No Rican, etc.)	,		White,		
336	al', or	by	3 ☑ Widowed 4 ☐ Divorce	If Yes Give			1 ☐ Yes 2	⊠ No	Specify:			5	Specify:		White	
21215-0036	72 hours affer death with the Maryland natural', or Items 23a or 28a-1 show dical Exam net must be tradified at	Completed		nt's Education		16a. Dece	dent's Usual	Occupa	tion	-4 -4		16b. Kin	d of Busi	ness/In	dustry	
215	within 7 ene. than "n	ple	Elementary/Secondary (0-12)	est grade completed) College (1-40	r 5+)	lite.	kind of work DO NOT use	retired)	uring most	or worki	ng					
	od wil	Con		5+		Te	acher					P	ubli	c S	chools	
nd	tal Hydral doth	Be	17. Father's Name (First, Middle						18. Mother	r's Name	(First, Middle,	, Maiden S	lumame)			
<u>ya</u>	ould Men arke	2	Pierre A. Pi								elle M.					
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Expr. a.c. must be inclined at		19a. Informant's Name/Relation								il Route Numbe					
	and lealth m 27		Michele Jamet	/ Daughter	001 5				ley R		Ijams					754
O	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from Stat	Geo	Place of Dispo cemetery, crer rge Wa Ho	natory or oth Shinet	e or er place CON)	L	Date	20c. Loc	ation - Ci	ty or To	wn, State	
ţ	tmen tant:		'4 ☑Donation 5 ☐ Other (5,2006					
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service	Licensee							uffer					
	40360		Y XXXX								ce Fre		k, M	ary		
			23a. Part1. Enter the disease, shock, or heart failure. Lis	t only one cause on each	ine.	n. Do not ent					_				Approximate Interval Betw Onset and D	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)	a			1)0	re	un	10	me	On				
	/Medical Examiner		rosuming in death)	Due to (or a	s a conseq	uence of):	IJ									
		-	Sequentially list conditions,	b. Due to (or a	s a consec	neuce of).	·									
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	4	3 2 0011304	401100 017.										
	xecu and	xar	that initiated events resulting in death) Last	c	s a conseq	uence of):										
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	alE														
687	ficate p phy: s the	Physician/Medical		d												
Вох	leath certifica attending ph I for use as th	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								23	d. Date o	of delive	PITY	
ă	death atte d for	Icla	in the past 12 months? 1 □ Yes 2 🖾 No	1□Live birth 4□Pregnant			Ectopic prec Other (spec						Month			ear
P.0	that the de	hys	9 Unknown	9□Unknown												
	res that igned be be det	by P	Part II. Other significant conditi	ons contributing to death	but not res	ulting in the u	nderlying cau	use giver	n in Part I.		23e. Did to	obacco use	e contribu	ute Io th	e cause of de	ath?
Records,	w require been sig should b										101	Yes 2□	No 3	☐ Prob	ably 4 Do	nknown
000	law requas been 2 should	Completed									24a. Was		24b. We	re auto	osy findings a	vailable
	certificate ha	E										rmed?	dea	ith?	npletion of ca 2⊠ No	use or
ta	rtifica	0	25. Was case referred to medica	ıl					26. Place	of Death	(Check only o				290,110	
of Vital	d is	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa	ient 2 🗆	ER/Outpatien	t 3 DOA	Other	r. 4 Nur	sing Hor	ne 5 🗆 Resid	dence 6	Other	(Specify	')	
0 0			27. Manner of Death 1 ☑Natural 5 ☑ Pendi	28a. Date of In (Month, D	ury ay Year)	28b. Time of Injury	280	. Injury			28d. Describe h					
Sio	Attending r death. sctor: Afterby the fune	catil	2 Accident invest	igation			М	1 🗆 Y	es 2□N	10						
Division	l or Attendation after deati	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 286. Place of I	njury - At ho etc. <i>(Specif</i>)	ome, farm, str	eet, factory,	office		2	28f. Location (5 City or Tox		Number	or Rura	Route Numb	er,
	ospital or A hours after uneral Dire ly filled in by															
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifyin (Check only one)	ng Physicien: To the bes Examiner: On the basis and manner:	of examina	wledge, death tion and/or inv	occurred at estigation, in	the time n my opi	e, date and inion, death	l place, a h occurre	and due to the a ed at the time,	cause(s) a date and p	nd mann lace, and	er as st I due to	ated. the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certific	er A			29c. I	License	number			29d. Date	signed (A	Jonth,	Day, Year)	
			Smut	mas	N	12		DS	83	91		05	-15	5-0	06	
1	1		30. Name and address of person	who completed cause of	death (Item	n 23a) (Type,	الله Print)			1 1			, .			
_	1		Sajjad A. Aziz	z, M.D. 80	1 To1	1 Hous	e Aven	ue	Fred	eric	k, Mary	yland	217	01		
	Sta		31. Date filed (Month, Day, Year,		ar's Signa		1									
	Regist	rar	MAY	15 2006	Leve	, St.	Good	U								

			For State Registrar	State of Ma	aryland /		irtment of H <i>tificate of l</i>			giene	006	16702
		24	Decedent's Name (First, Middle, Last)						2. Date of Dea	ath		3. Time of Death
	Physici /Medic		Hel	len Eilee:	n Haml:	in			May	Day	100G	14:40M
10	Examin		4a. Facility Name (If not institution, give s	treet and number)				Location of Death			unty of Death	
		Ş,	213 Patriots Way				E1kton				ecil	
	Funeral Director		300-10-0493	7. Ag	e (In yrs. last 2	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da NOV 7,	1923	9. Birthpl Count Ohi	ace (State or Foreign try)
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation				10	Od. Inside City Limits
	the Marylar 28a-f ahow	ō	Maryland Cecil		F11	kton						1 Tyyes 2 □ No
	28a	rec	10e. Street and Number		1 111	K L OII	10f. Zip Code			10g. Citizen	of What Coun	try?
	h with	D E	213 Patriots Way				21921			Un	ited St	ates
	deet	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	spanic Origin? (Sp	pecify Yes or No-	- 14.	Race - America Black, White, e	
21215-0036	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic avant, the Medical Examinational be mailing at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			☐Yes 2X No	Specify:	7 1102111 010.7	1	ecity: Whi:	
5-0	72 h	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	11	6a. Deced (Give	lent's Usual Occupa kind of work done of OO NOT use retired	ation during most of work	king	16b. Kind o	of Business/Ind	lustry
121	within ne.	шp	Elementary/Secondary (0-12)	College (1-4or 5	5+))		т. т	Τ- Ο	77
	Hygie ther t		12 17. Father's Name (First, Middle, Last)			поп	emaker	18. Mother's Nam	na (First Middle		Her Own	ноте
an	d be ental c ava	To Be	Robert Knox Reisi	inger					et Grove		,	
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "reumatic avant, the Men	F	19a. Informant's Name/Relationship (Type		1	9b. Mailin	g Address (Street a				wn, State, Zip	Code)
	and 2 Baith a n 27 is		Beth C. Hamlin/Da	aughter		2432	Brown St	reet, Phi	iladelph	ia, PA	A 19130	
ore,	of Heron Itam		20a. Method of Disposition				sition (Name of natory or other place		Date		ion - City or To	
Baltimore,	Pe ne me ne ne ne ne ne ne ne ne ne ne ne ne ne		1 ☐ Burial 2 ☒ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	5		Cheste						
B	Departr Importr any inj		Mister Hicke	Ereman		Hi	Name and Address Cks Home 3 W. Sto	for Fune ckton Sti	erals, P reet, El	.A. kton.	Marvla	nd 21921
2			23a. Part. Enter the disease, or complishook, or heart failure. List only or	cations that caused	the death. D							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CD	PD							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	ce of):	-					years
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	ped list	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequent	ce or):						
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68760,	flicate be executed g physicien and as the burial-transit	calE		1								
.89		edical								-		
O. Box	The law requires that the death certifules been signed by the attending tage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea	ath 3	Ectopic pregnancy Other (specify)			23d.	Date of deliver Month	ry Day Year
٥.	s that ned b e deta	by Pr	Part II. Other significant conditions con	tributing to death b	ut not resultin	g in the ur	derlying cause give	en in Part I.	23e. Did to	obacco use d	contribute to the	e cause of death?
rds	quire en sig ruld b	edt							A	res 2□N	o 3 🗆 Probe	ably 4 Unknown
of Vital Records,	aw re	Completed							24a. Was		4b. Were autop	sy findings available
Ä		E								rmed? 2021 No	death?	1000
/ita	clan: ertific ector,	Be	25. Was case referred to medical examiner?					26. Place of Dea				
of \	Physician: this certific ral director,	2	1 1 162 2 140		ent 2 ER/			4 Nursing H	ome 5 Resid)
Z	After After Tune	lon	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28t	b. Time of Injury	28c. Injun Worl		28d. Describe h	now injury oc	curred	
Division	l or Attending effer death. Diractor: After i in by the fune	lcat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Ini	ury - At home	farm str	eet, factory, office	Yes 2 □ No	28f. Location (S	Street and N	umber or Rum	Poute Number
ē	efter efter Dire	Certification:	4 Homicide determined	building, et	c. (Specify)	1 121111, 3111	ot, factory, office		City or Tou		umber of rigida	riodio restiber,
	To the Hospital or Attend within 24 hours effer death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physical Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best ner: On the basis o and manner st	t examination	dge, death and/or inv	occurred at the time restigation, in my of	ne, date and place, pinion, death occur	and due to the cred at the time,	cause(s) and date and pla	d manner as sta ce, and due to	ated. the cause(s)
	To the Mithin To the	Me	29b. Signature and title of certifier				29c. License	number		29d. Date si	gned (Month, L	Day, Year)
	0		If Jarkas	, MD			DI	5314		May	12,2	006
	7		30. Name and address of person who co	mpleted cause of d	leath (Item 23	a) (Type,	Hoeline	FILTO	n M	2		
3	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	,	MOJICE	LIKI	17 /- 19	/		
	Registi		MAY 1.2.200	16 /	w H	do	Hospice,					
-	1 41 1 4 m m		min - a Lui	- July Company								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2006° **Physician** May 8, 9:30A. M Siu Hua Hiam /Medical 4c. County of Death
Montgomery 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Takoma Park Sligo Creek Nursing Home | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 28,17317 7. Age (In yrs. last birthday) 89 Yrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days 219-41-6650 1 ☐ M 2X F China Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location Hygiene. stherthan "naturel", or fleme 23a or 28a-f show ent, the Medical Examiner must be notified at 10a. State Maryland Prince George's College Park 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 4711 Berwyn House Road, #715 China Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Asian Baitimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher permit. Peges 1 and 2 should be filed wi.
Department of Health and Mental Hygien.
Importent: If Item 27 is marked other thi
any fujury or other treumatic event, i.m. 17. Father's Name (First, Middle, Last) 18, Mother's Name *(First, Middle, Maiden Surn*am*e)* 19a. Informant's Name/Relationship (Type, Print)
Lydia Shen -daughter 19b_Mailing Address (Street and Number or Rural Roule Number, City or Town, State, Zig Code) 4711 Berwyn House Road, #615 College Park, Md. 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MD National Mem. Park 5/11/2006 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA a 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Physician Aspiration Pneumonia 1 week resulting in death) /Medical Due to (or as a consequence of): Examiner Colon Cancer with bleeding 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and s the burial-transli Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ettending physic I for use as the b IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the etter should be detached for in the past 12 months? 1 ☐ Yes 2 No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performed 1 Yes 2 XNo 1 Yes 2 No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐XNo 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and May 9, 2006 D21900 2. DOM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Smith Ho, M.D. 7610 Carroll Avenue, #280 Takoma Park, Maryland 20912 32. Engistrar's Signature 31. Date filed (Month, Day, Year) State MAY 11 5000 Registrar DHMH 17 Rev 1/2001

			For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment <i>tificate</i>	of He	ealth a <i>eath</i>	and M	ental Hyg	iene eg. No.	2006	167	704
	Physici	200	1. Decedent's Name (First, Midd	fle, Last)							2. Date of Dear Month	th Day	Year	3. Time of	
	Physicia /Medic		MARY F. HARKINS								MAY	9,	2006	12:00	P M
	Examin	er	4a. Facility Name (If not institution CASEY HOUSE	on, give street and nu	ımber)		4b. City, To	own, or l OCKVI		of Death			County of Death MONTGOMERY		
	Funeral Director		5. Social Security Number 261-42-1360	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 74		If Under 1		If Under 2 Hours	24 Hrs. Min.	8. Date of Birth			lace (State or	Foreign
	ם		Usual Residence of Decedent												
	ehow	5	10a. State 10b. Count MARYLAND MONTG		10c. C1	ty, Town or Lo SILVER S								0d. Inside Cit 1 ☐ Yes	*
	the h	Director	10e. Street and Number			JEN E	10f. Zip C	Code			1	0g. Citiz	en of What Coun	try?	
	h with	al Di	2429 COUNTRYSIDE	DRIVE			20	905				US	SA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-f show eny lighty or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 XDivorce	rried Armed F	2 Å No ive		Was Deceder f Yes, specify	y Cuban	panic Orig , Mexican Specify:	gin? (Spe i, Puerto	ocity Yes or No- Rican, etc.)		4 Race - Americ Black, White, Specify: WHI	etc.	
Maryland 21215-0036	thin 72 hou e. en "natura Medical E	Completed		nt's Education est grade completed, College) (1-4or 5+)	(Give	dent's Usual (kind of work DO NOT use	done du	ion uring most	t of worki	ng	16b. Kin	d of Business/Inc	lustry	
7	led wil	S	47 Pathada Nama /Piant Middella	2		SECRE	TARY		10 Matha	da Nama	(First, Middle,		DUCATION		
and	d be fi	Be C	17. Father's Name (First, Middle GEORGE FRANCIS								SHALL	walden S	sumame)		
ير	should nd Me mark mark	P	19a. Informant's Name/Relation			19b. Mailir	ng Address (S	Street ar				. City or	Town, State, Zip	Code)	
ž	and 2 alth a 27 is		GARY P. HARKIN	S - SON		2429 0	COUNTRYS	SIDE 1	DRIVE;	SILV	ER SPRING	MD 2	20905		
Baltimore,	Pages 1.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (State	Place of Dispo cemetery, crer CT LINCOI	natory or oth	er place,	1	5/13/			ation - City or To	wn, State	
Balt	permit. Depertr importa		21. Signature of Funeral Service Myelin	Licensee Tr Klol	et		. Name and .800 NEW			1111			NERAL HOME G MD 20904		
	Physician /Medical Examiner		23a. Part1. Enter the disease, can shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)	aCE	caused the deal each line. REBROVASO (or as a consec	ULAR DIS		of dying,	, such as	cardiac o	r respiratory arr	est,		Approximate Interval Betw Onset and D	veen
8760,	icate be executed physicien and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	(or as a consec										
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۵.	sign d be	by	Part II. Other significant condit DEMENTIA	tions contributing to	death but not res	sulting in the u	nderlying cau	use giver	n in Part I.			oaccous es 2 🔀	e contribute to th	e cause of de ably 4 DU	
Division of Vital Records,	The law requirate has been page 2 should	Completed									24a. Was a autops perform		24b. Were autoprior to condeath?	npletion of ca	ivailable luse of
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medic examiner?	Hospital:				Other			(Check only on		v	, HOSPIC	·E
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ion	Attending r death.	atior	1 ☑Natural 5 ☐ Pend	ing (Mo	nth, Day Year)	Injury	М		? es 2 🗆 l						
Divis	5 th to	Certification:	3 ☐ Suicide 6 ☐ Coule 4 ☐ Homicide deter	mined 288. Place	e of Injury - At h ling, etc. (Speci	iome, farm, str fy)	eet, factory, o	office		3	28f. Location (Si City or Town	treet and n, State)	Number of Rura	l Route Numb	ρθ <i>Γ</i> ,
	ha Hospital in 24 hours he Funerel pletely filled	edical	29a. Certifier 1 Cartify (Check only 2 Medice one)	ing Physician: To the Il Examinar: On the and ma	e best of my knobasis of examination	owledge, deatl ation and/or in	occurred at vestigation, in	t the time n my opi	nion, deal	d place, a	and due to the cand at the time, d	ause(s) a ate and p	and manner as st place, and due to	ated. the cause(s)	
	To the Vithin 2 To the complete	Σ	29b. Signature and title of certif	ier E			29c. i	License	number		2	9d. Date	signed (Month, I	Day, Year)	
,	1		1 Chihe	John	2			42452	2			MAY	10, 2006		
	1		30. Name and address of person CHAITRA RAJAGOPA		ise of death (Ite OL MUNCAS			ROCKV	/ILLE	MD 20	850				
	Sta Registi		31. Date filed (Month, Day, Yea		Pegistrar's Sign							-			

State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** May ያී**,** 2008 Vicinthia Healey 12:00 P.M Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's N. Brentwood 4508 41st Avenue If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth (Month, Day, 7/29/39 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 ☐ M 2 🖫 F 66 Yrs. Director 578-56-8359 Wash.,D.C Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show other traumatic svent, the Medical Examiner must be notified at Md. 1 ☐ Yes 2 ☐ No P.G. Completed by Funeral Director N. Brentwood 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4508 41st Avenue 20722 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White etc. African-1 Never Married 2 Married 1 ☐ Yes 2 No Specify: American 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Seamstress Upholstery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jessie Johnson.Sr. Loretta Stockett ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Healey/Husband 4508 41st Ave., N. Brentwood, Maryland 20722 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition XXBurial 2 Cremation 3 Removal from State Ft. Lincoln Cem. 5/20/06 * 4 □ Donation 5 □ Other (Specify) Brentwood, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ćause (Final CIHOMATO Physician disease or condition resulting in death) /Medical Examiner BET RETROMOLAR AREA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Box (IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by URALEFFUSION @ PHEUMONITIS 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown CHRONIC OBSTRUCTIVE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy MONAR 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Mesidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manuer of Death 1 W Natural 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation death. 1 Yes 2 No 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hour. the Funeral Directory Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, P MOHAMM ED 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 6 2006 Registrar

			1 - For State Registrar	State of Marylan		tment of He			Reg. No.	16706
pk	Physici		Decedent's Name (First, Middle, La SUN I H	ist) IYON				2. Date of Dea Month MAY	Day Year	3. Time of Death 8:54P
	/Medio		4a. Facility Name (If not institution, giv	e street and number)	4	lb. City, Town, or I	Location of Death		4c. County of De	
-			GLADYS SPELLMA	N HOSPITAL			rsville		PRINC	E GEORGE
	Funeral			Sex 7. Age (In yrs. 1 1 ☐ M 2 🛱 F 72		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year) 9. B	rthplace (State or Foreign Country)
1	Director		Usuel Residence of Decedent	- X /Z	113.			MARCH	6,1934	S KOREA
	/land		10a. State 10b. County	10c. Cit	y, Town or Loca	tion				10d. Inside City Limits
	Mar	tor	VA FAIRFA	X FA	AIRFAX					1 ☐ Yes 2 ☐XNo
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	23a	rai	13601 ROGER M	IACK CT		20151			S. KORE	A
	tema arm	nue	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Wa	s Decedent of His es, specify Cuban	panic Origin? (Sp., Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1]Yes 2√ No	Specify:		Specify:	ASIAN
21215-0036	72 hours after death with the Maryland natural', or Itema 23a or 28a-1 show disal Examinar must be trofitted at	ed	15. Decedent's E	<u> </u>	16a. Deceder	nt's Usual Occupat	tion		16b. Kind of Busines	
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nd	be filed ital Hygi of other event, I	Be	17. Father's Name (First, Middle, Last,)			18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
yla	should nd Men marke umatic	ဥ		IM			GIN GA			
Maryland	~ ~ ~ ~		19a. Informant's Name/Relationship (_			r, City or Town, State,	
	1 and 2 Health em 27		CHONG MIN HYO 20a. Method of Disposition		lace of Disposit	1 ROGEI		Date CHA	NTILLY VI 20c. Location - City of	
ПÕГ	0 0		1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	emetery, crema	tory or other place,)			
altimore,	2 2 t 2 .		21. Signature of Funeral Service Licer	MUT		MEMORIA lame and Address		15/06	FAIRFAX	VA
B	Depa Impo any I		X A HZ	\checkmark	12	303 KD2	CHA VAK DR	KLES H	INDS FUNI MARLBORO	ERAL SERVIC
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease or common shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	plications that caused the death one cause on each line. a. RESPIRATOR Due to (or as a consequence) Due to (or as a consequence)	ey F	the mode of dying,	, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
x 68760,	certificate be executed ding physician and se as the burial-transit	Physician/Medical Examiner	resulting in death) Last	c						
P.O. Box	The law requires that the death certifical site has been signed by the attending phy age 2 should be detached for use as the	hysician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 E	ctopic pregnancy other (specify)			23d. Date of de Month	Day Year
	s that	by P	Part II. Other significant conditions of	contributing to death but not resu	ulting in the unde	erlying cause given	in Part J.	23e. Did to	bacco use contribute	o the cause of death?
ğ	w requires t been signe should be	edit	CHRONIC RENAL	FAILURE CO	RONARY	ARTERY	DISEA	SE 10Y	es 2 No 3 F	robably 4 Unknown
of Vital Records,	ysician: The law n is certificate hes be director, page 2 sh	Completed						24a. Was a autop perfor	sy prior to death?	utopsy findings available completion of cause of s 2 \(\square \text{No} \)
<u> </u>	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	26. Place of Deat	h (Check only or	ne)	
ō	ھ ≑ ھ	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatient 2	ER/Outpatient 28b. Time of	3LI DUA	4 Nursing Ho		ence 6 Other (Specow injury occurred	ecify)
O	Attending Physician: r death. sctor: After this certifice by the funeral director.	tio	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury a Work? M 1 26	es 2 No	200. 2000.100	ow injury coouning	
Division	i Pite o	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ome, farm, street	, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	ural Route Number,
	- 14 - 0	edical	one)	nysicien: To the best of my know miner: On the basis of examinat and manner stated.	wledge, death or tion and/or inves	tigation, in my opir	nion, death occur	and due to the or red at the time, or	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier			29c. License i		2	9d. Date signed (Mon	
	(2)		Ilste M.	UB MO		D0026	0024		5/	12/06
2	131		30. Name and address of person who						2000	
6	Sta	to	LESTER MILES 1 31. Date filed (Month, Day, Year)	MD 6490 LAND Registrar's Signal		ט, LAN	DOVER	, MD 2	20785	
35	Registr		MAY 1 5 2000		Mark	2.5				

			1 - For State Registrar	State of Mar	ylar		artmer	nt of H			ental Hy			6	16707
П	Physic		Decedent's Name (First, Middle, Last Cora Louise Har) tman							2. Date of De Month May	7,	2000		Time of Death
>	/Medi Examir		4a. Facility Name (If not institution, give Holy Cross Renabilitat	street and number)	g Cen	nter			Location of		гау		County of De Montgo	eath	12:00Pw y
	Funeral Director		5. Social Security Number 575–18–5389 6. Se Usual Residence of Decedent	7. Age ((In yrs. 8.	last birthday) 5 Yrs.	If Unde Months	n 1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da April	2,1	921 Soi	Country	(State or Foreign Carolina
	within 72 hours after deeth with the Maryland ene. then "natural", or items 23a or 28a-1 ehow ha Madical Examiner must be cigillied at	Director	Maryland 10b. County Prince G	eorge's	Col	y, Town or Lo	ark 10f. Zij						tizen of What (Country?	
036	permit. Pages t end 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or items 23a or 28a-f show empty injury or other traumatic event, the Madical Examiner must be retilied at anone.	Be Completed by Funeral Director	6200 Westchester F 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		.S. 13. \		v		in? (Spe Puerto f	cify Yes or No Rican, etc.)		14. Race - An Black, Wh Specify:	nencan I	
21215-0036	d within 72 ho giene. in then "natur the Madical.	completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	2 _	16a. Deced (Give life. L Admin	kind of wo DO NOT u	rk done d se retired,	tion furing most	of workin	g		Cind of Busines	ss/Indust	ry
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Mar	alth and 2 sh		19a. Informant's Name/Relationship (Ty Charles C. Hartman	pe, Print) -husband		19b. Mailin	ng Address Westo	(Street a hest	nd Number er Pa	rk D	rive,#	717	College	e Pa	rk,Md.207
imore	Pages to		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			lace of Dispo emetery, cren ropoli				5/9/			ocation - City o		
Ba	Depermit Depermit impor eny in		21. Signature of Funeral Service Licens	March		1 BC	5ha1a 400 P	owde	Bofgwa r Mill	ardt L Roa	Funera	al H svi	ome, PA	A arvla	and 20705
	Physician and // // // // // // // // // // // // //	Examiner	23a. Part1. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, but my Jume distactuse. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	ie cause on each line.	SJ CV	uence of):	er the mod	e of dying	, such as ca	ardiac or	respiratory ar	rest,		App	oroximate orval Between set and Death
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rds, P.	w requires that the bound by should be determined by the contractions of the contracti	Ω	Part II. Other significant conditions cor	tributing to death but n	ot resu	ulting in the un	derlying c	ause giver	n in Part I.				ise contribute t		use of death?
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DIVIS	7 8 5 5	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	Specify)					City or Tow	n, State			
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)	Mithin comp	Me	29b. Signature and title of certifier Williams Wil	v Mp				License			2		e signed (Moni	th, Day,	Year)
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	Sta Registra		31. Date filed (Month, Day, Year)	32. R- o strar's	Signat	Ure A	DOME.								

		1 - For State Registrer	atë of Marytand / Dep <i>Ce</i>	artment of Health a ertificate of Death		giene [] [Reg. No.	16 16/08
40		Decedent's Name (First, Middle, Last)			2. Date of De.		3. Time of Death
Physic		Stuart W. 1	Hallock		Month May 7		2:50 P M
/Med Exam		4a. Facility Name (If not institution, give stree	t and number)	4b. City, Town, or Location of	Death	4c. County o	
- Addition	20	1232 Ritchie Highw	av	Arnold		Anne	Arundel
Funera		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year If Under 2			Birthplace (State or Foreign Country)
Directo		095-01-2951 [™]	2□F 87 Yrs.	Months Days Hours	Min. (Month, Da		
× Y'		Usual Residence of Decedent	07		0000. 10	, 1910	New York
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Man	ţ	Maryland Anne Arun	del Arnold	1			1 ☐ Yes 2 🙀 No
ith the Marylan or 28a-f show	Director	10e. Street and Number	der Ainore	10f. Zip Code		10g. Citizen of Wi	nat Country?
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leath ms 2	era	11. Marital Status 12. V	Vas Decedent Ever in U.S. 13.	Was Decedent of Hispanic Orig	in? (Specify Yes or No	USA - 14. Race	- American Indian,
tter o	Funeral	<i>F</i>	Armed Forces?	If Yes, specify Cuban, Mexican,	Puerto Rican, etc.)		White, etc.
id (12.12.12.10.00) If ide within 72 hours after death with the Maryland Hygiene. Ither than "nature!", or items 23a or 28a-f show int, the Medical Examinary number natified at	ρ	3 Widowed 4 □ Divorced	Tyes 2 No Yes, Give Year or Dates: 1942-46	1 ☐ Yes 2 ☐ No Specity:		Specify 1	White
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n Z	Completed	(Specify only highest grade con	mpleted) (Given life. College (1-4or 5+)	e kind of work done during most DO NOT use retired)	of working	Public	Television &
the set	E	Elementary/Secondary (0-12)	1	nt Director		Radio	relevision «
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mari mari	-	19a. Informant's Name/Relationship (Type, I		ing Address (Street and Number	e Livingsto		tate Zin Code)
d 2 st d 2 st d 4 st d		Linda Katz/ Daughte:		Sigma Drive, Ha			
Head The		20a. Method of Disposition	20b. Place of Disp	osition (Name of	Date		ity or Town, State
2 8 5 2 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo	val from State	ematory or other place) Memorial Park	May 12,		,
I P. P.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee A			2006		.e, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injuy or other treumatic event, the Medical Exposition must be notified at any increase.	X	Willia J	B ₂ Fr	2 Name and Address of Facility ancis J. Collin 00 University B	ns Funeral lvd, W, Sil	Home Inc Lver Spri	e. .ng, MD 20901
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ons that caused the death. Do not en	nter the mode of dying, such as c	ardiac or respiratory ar	rest,	Approximate Interval Between
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wrequires that the death certiful been signed by the attending should be detached for use a.		IF FEMALE: 23c. II	f yes, outcome of pregnancy			23d. Date	of delivery
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ding Phys	on:	27. Manner of Death 1 Natural 5 Pending	Ba. Date of Injury 28b. Time ((Month, Day Year) Injury	28c. Injury at Work?	28d. Describe h	low injury occurred	1
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or Att	Certification:	3 Suicide 6 Could not be determined	Be. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office	28f. Location (S City or Tox	Street and Number m, State)	or Rural Route Number,
is af							
To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Exeminer:	n: To the best of my knowledge, dea On the basis of examination and/or in and manner stated.	th occurred at the time, date and nivestigation, in my opinion, death	place, and due to the on occurred at the time, o	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)
o th	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Dey, Year)
211		16.8-2.60	(13	D3300	001	5/91	10C
>1		30. Name and address of person who comple	eted cause of death (Item 23a) (Type				
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San S	tate	31. Date liled (Month, Day, Year)	32. Signature	Leads 9	1110	· control	1-
Regis	trar	MAY 1 1 2008	Blaque D. My				

		•	For State Registrar	State of M	laryland		rtment of H tificate of L		d Menta	l Hygiene Reg. No	ZIIIIb	16709
			Decedent's Name (First, Middle, Las	st)					2. Date Mor	of Death	y Year	3. Time of Death
	Physicia /Medic		James		Wesley	У	Hi11		m		2066	8:00 A-M
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	Director		218-12-5627 Usual Residence of Decedent	Λ	04	113.			04/	27/1922	Mar	yland
200	wand		10a. State 10b. County		10c. City,	Town or Los	cation					10d. Inside City Limits
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1	7 28 P	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of Whal Co	ountry?
-	23a C	aD	10122 Christ	ie Road,	SE			21502			USA	
0	within 72 hours atter death with the Maryland ene. Than "natural", or items 23e or 28e-f show fre Modicel Examiner must be notilied at	Funeral	11. Marital Slatus	12. Was Deceden Armed Forces	t Ever in U.S.	. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin' n, Mexican, P	? (Specify Ye	s or No- etc.)	14. Race - Ame Black, Whit	
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פ	Hygid other	BeC	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First,	Middle, Maidei		
a	ked o	To B	Brethard		Hil:	1		Beul	ah	E11	en A	labaugh
Maryland	2 should be filed within 72 hours atter death with the marylan and Mental Hygiene. and Mental Hygiene is marked other than "natural", or Items 23e or 28e-1 show aumatic event, the Medical Examinar mast be inclifted at		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a	and Number o	or Rural Route	Number, City	or Town, State,	Zip Code)
Σ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce.		Evah J. Hill / v	vife			22 Christ	ie Roa	d, SE.			
Baltimore,	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	l cor	ice of Dispo metery, cren	sition (Name of natory or other place	a)	Date	20c. L	ocation - City or	Town, State
Ĕ	Pag nent ant: I		4 Donation 5 Other (Specify				emorial P				umber1a	
a	Depart Depart Import eny Inj		21. Signature W Furwral Service Licen	isee		22						Home, P.A.
<u> </u>	40 E # 0		Xahert C.	allan			404 Deca				and, MD	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only			Do not ente	er the mode of dying	g, such as car	rdiac or respir	atory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a. LEW	ly Bo	YUC	DEMENT	TA				8 MONTHS
	/Medical Examiner		resulting in death)	Due to (or a	is a conseque	ence of):						
	- Adminior		and the second s									
		-	Sequentially list conditions,	b. Construtor for a	era encarectos	enne offi						
	led Isit	nlner	cause. Enter Underlying Cause (Disease or injury		s a conseque	ence of):						
	xecuted n and at-transit	xamlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a conseque							
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ox 68760,	n certificate be executed anding physician and use as the buriat-transit	ca	cause. Enter Underlying Cause (Disease or injury that initiated events	c. Due to (or a	is a conseque	ence of):	Estania praggana				23d. Date of de	
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State of Maryland / Department of Health and Mental Hygier	ıe/	U	U

		1 - For State Registrar	State of Mary		artment of H tificate of L		Mental Hy	/giene	2006	16710
Physic	ian	Decedent's Name (First, Middle, Las	")				2. Date of D Month	eath Day	Year	3. Time of Death
/Med		DOROTHEA MAE HE			41. Oh. T	Landing of Base	Muy		2006 County of Dear	07:55AM
Exam	ner	4a. Facility Name (If not institution, give 200 THIRD STREET		7-06-1-46-7-1	4b. City, Town, or CHESAPE. If Under 1 Year	AKE CITY			CECIL	thplace (State or Foreign
Funera Director		218-16-5/92	M 2X F 7. Age (//	n yrs. last birthday) 87 Yrs.	Months Days	Hours Min.		av Year)	918	MARYLAND
land		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation					10d. Inside City Limits
Mary Ined	ţō	MARYLAND CECIL		CHESAPEA	KE CITY					1 Yes 2 □ No
th the	Director	10e. Street and Number			10f. Zip Code				en of What Co	•
death with the Maryland ms 23a or 28a-f show rmust be notified at		200 THIRD STREET			21915	. 00/	2		ED STA	
ING KIKIDOOO be filed within 72 hours after death with the Marylar tal Hygiene. d other then "natural", or liems 23a or 28a-f show event, the Wedfoal Exam the must be motified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	Specify:	to Rican, etc.)		Black, White	e, etc.
72 hor	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occupa	turing most of wo	nrking	16b. Kin	d of Business	/Industry
vithir N	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired MEMAKER)		OWN	HOME	
Maryland & 2 should be filed v n and Mental Hygie 1's marked other t reumatic event, th		17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	1		
	o Be	ANDREW JACKSON S	STEVENS			KATHER	NE REBE	CCA A	CKERS	
ire, Maryie s 1 and 2 should f Health and Men item 27 is marks other treumatic		19a. Informant's Name/Relationship (7	ype, Print)		ng Address (Street a					
= B#2.		STERLING HERSCH/HI			THIRD ST.	, CHESAI				
MOTE, Pages 1 a nent of Hea int: If item		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, cre	natory or other plac		Date		cation - City or	
Baltimo permit. Pages Department of important: If i any injury or		4 Donation 5 Other (Specify		BETHEL CI						E CITY, MD
Dattimo		21. Signatur TF heral Service Licen	MITIL		2. Name and Addres 18 GEORGE					
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/Medica		disease or condition resulting in dealh)	a. Due to (or as a c	onsequence of):						years
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68 / 60 ificate be a g physicier as the buri	dical		. d							
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dS, P.C. I	hys	9 🗆 Unknown					1			
S, es that igned be de	by	Part II. Other significant conditions of	ontributing to death but r	not resulting in the t	inderlying cause give	en in Part I.				o the cause of death?
COTC	ted						14	Yes 2	1	
leC has b	Completed						24a. Wa	s an opsy formed?	24b. Were a prior to death?	utopsy findings available completion of cause of
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VITAI HECOTGS, sicien: The law requires t certificate has been signe rector, page 2 should be o	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient	0 □ EB/0	oth Oth	er	eath (Check only			
Phys r this ral dir	5	1 ☐ Yes 2 ② No 27. Manner of Death	28a. Date of Injury (Month, Day Y	2 ☐ ER/Outpatie	III JUDON	4 Nursing	Home 5 Re-			киу)
DIVISION OF I or Attending Phy after death. Director: After this d in by the funeral d	ation	1 Natural 5 Pending 2 Accident investigation	1	ear) Injury		k? Yes 2 ∐No				
DIVISION C of or Attending F after death. I Director: After d in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, st	reet, factory, office			(Street and		ural Route Number,
UIV tel or A rs after el Dire	Cert		January, etc. (1			
DIVISION OF VITA To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifying Ph (Check only one)	ysician: To the best of r niner: On the basis of ex and manner stated	amination and/or in	th occurred at the line occurred in the line occurred at the line occurr	ne, date and plac pinion, death occ	e, and due to th curred at the time	e cause(s) e, date and	and manner a place, and du	s stated. e to the cause(s)
o the o the omple	Med	29b. Signature and title of certifier	/		29c. Licens	e number		29d. Date	e signed (Mon	th, Day, Year)
⊢≯⊢ŏ		1 N. Xarl	las MD	1	019	5314		Man	, 12,	2006
2		30. Name and address of person who	completed cause of deal	th (Item 23a) (Type	Print) Hospice	Ell	fon	מני	210	3 2 1
5.5 A	tate	31. Date filed (Month, Day, Year)	32. Registrar's		14 7/10	- 11	', ',			
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DHMH 17 Rev	/2001		1 - 3	and the same	1					

ORIGINAL

			1 - For State Registrar	State of Marylan	-	artment of F			iene _{•g. No.} 20 (06 1671
)	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last Earl 4a. Fecility Name (If not institution, give	Louis		Jewell 4b. City, Town, o	r Location of De	2. Date of Dear Month	Day Ye	P 7:10 A.M.
,	Funeral Director	C.		HOSPITAL 7. Age (In yrs. I	last birthday) Yrs.	Cumbe If Under 1 Year Months Days	Rland If Under 24 Hi Hours Mi	8. Date of Birth (Month, Day)	Alle G.	Birthplace (State or Foreign Country)
	D D	or	213-24-5604	10c. City	y, Town or Lo	cation Cumberla	and and	02/14/1	.928 Ma	aryland 10d. Inside City Limits 1 □ Yes 2 ☑ No
imore, maryland z i z i 3-0036	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mentel Hygiane. Hygiane. Proportents if feem 27 is marked other then "neturel", or items 23s or 28s-f show eny injury or other treumatic event, the Madical Examinar must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 15704 Packard I 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Dovorced 15. Decedent's Edit (Specify only highest grade) Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last)	Prive, SW 12. Was Decedent Ever in U. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 194 Ication (e completed) College (1-4or 5+) 2. sfield Arpe, Print) Son Removal from State MD	Jew 19b. Mailir 1025 Place of Dispo	Was Decedent of H I Yes, specify Cube II Yes, specify Cube Was Decedent of H I Yes, specify Cube II Yes 2♥ No II Yes 2♥ No II Yes 2♥ No II Yes 2♥ No II Yes 2♥ No II Yes 2♥ No II Yes 2♥ No II Yes 2♥ No II Yes II	ispanic Origin? (an, Mexican, Pue Specify: ation during most of with the second standard Number or File Road (ce)	Specify Yes or North Rican, etc.) orking ame (First, Middle, In Editor Route Number of Bedford Date 05/22/20	Black, V Specify: 16b. Kind of Busine Ballist Maiden Sumame) Ina City or Town, Stat 1, PA 15 20c. Location - City	white ess/Industry ics Long e, Zip Code) 522
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> :	yelci is cert direct	To B	examiner?	lospital: 1. Inpatient 2	ER/Outpatien	t 3 DOA Othe	or	eath (Check only on Home 5 Reside		Spacify)
) =	ter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe ho		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
DIVISION	To the Hospital or Attending Physicien: The law within 24 hours elfer dath. To the Funerel Director: Alter this certificate hes completely filled in by the funeral director, page 2.	Certification:	1 A Stural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	M 1 🗆	Yes 2 □No	28f. Location (St. City or Town	reet and Number or i, State)	Rural Route Number,
:	the Hospi thin 24 hou the Funer mpletaly fill	Medical	one) 2 Medical Bxami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	vestigation, in my or	pinion, death occ	curred at the time, da	ate and place, and o	due to the cause(s)
) 4 -	5/IVA		29b. Signature and title of certifier 30. Name and address of person who certifier	Ampleted cause of dooth the	23a) /T	29c. License			Od. Date signed (Mi	MD 21502
	TILS Sta Registr		31. Date filed (Month, Day, Year)	11 A POONA 32 Registrar's Signat	1 90	24 Seto	N DRI	ve Cum	berland	, MO 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 21 per day 2855 / 5-25-06 yt of Health and Mental Hygiene 2 0 0 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Year 10:33 P M May 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Prince George's

9. Birthplace (State or Foreign Doctors anham ITA If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Sex 1**X**M 2□F **Funeral** Days Hours 223-72-9958 Min Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Madical Examinar fourties notified at Prince Yes 2 No Directo anham 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code or itema 23a or Funeral 14. Race - American Indian, Black, White, etc. Specify: AFCI Can Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1X Yes 2 No 8-21 If Yes, Give Year or Dates: 2 25 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 Divorced "naturei", Americar Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working vite. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kjad of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) vate tenance 17. Father's Name (First, Middle, (ast) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental F is marked of 10 arks ya. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar important: If Itam 27 is any injury or other trau , Lanham, MD 20706 aroluntarme Baltimore, 20h. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State Maryland 21. Signature of Euneral Service Licensee James Lincoln 22. Name and Address of Facility 0 HSSOC. tuneral per dvr 23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myo cand Physician /Medical **Examiner** stati Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Dunknown 1 | Yes 2 | No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: Certification; To 1 Minpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 14/x006 Inames D53718 temam 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good Luck Road Lanham Md 20706 MD Hansson 82. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene? [] [] [1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 05 5:22AM JOHNSON 09 EORGE 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Heartland Healthcare Facility-Hyattsville Hvattsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03–30– 1948 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**M** M 2□ F Months Days Hours Min 51-80 58 Director South Carolina Usual Residence of Dewith the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show the Madical Examinar must be notified at MD Prince Georges College Park 1X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 8626 Cunningham Drive 20740-2780 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or iten any injury or other traumatic event, it is Marcical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ¾☐ No Specify: Specify: Black 2 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Private College (1-4or 5+) Elementary/Secondary (0-12) Finance Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Allen Johnson Esther Grice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 118 Weyposset St. New Haven , Conn Tyrone Oliver Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Glerwood Cemetery or other place) 1 XX urial 2 Cremation 3 Removal from State 05/16/06 Wash, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bianchi 814 Upshur St NW Wash, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENCEPHALOPATHY A NO XIC Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed ettending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by AFRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Waknown been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2 No certificate 2 No 1 Yes 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury Accident 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completely filled in by th 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier D0058290 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road 4203 Queensbury +IPA77UH SURESHKUMAR 31. Date filed (Month, Day, Year) State Registrar MAY 1 5 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#26.PerPhys.PGC 5-15-06 cr Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month 12:55 P^M May 5 2006 Barbara Jones 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 6201 Cipriano Road Prince George's Lanham | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 7, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Months 1 □ M 2 🕅 F 82 002-16-8907 1924 Mass. Usual Residence of Decedent 10c. City. Town or Location. 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No St. Clair Fairview Heights Illinois 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 62208 USA 312 Oulvey Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: 3 □ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alice Lavers Ernest Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Fairview Heights, Il. 62208 Sandra Grudzinski / daughter 21 Mt. Vernon Dr. 20b. Place of Disposition (Name of cametery, crematory or other place)
Jefferson Barracks 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Amemoval from State 05/09/2006 St. Louis, MO. 4 ☐ Donation 5 ☐ Other (Specify) National Cemetery 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licenses 6512 NW Crain Hwy. Bowie, Maryland 20715 1100 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final END STAGS CONGESTIUS HEART FAILURS disease or condition resulting in death) Due to (or as a consequence of): PULMONACE COR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) LUNG DISSASS OBSTRUCTUE CORRONIC Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

Physician /Medical Examiner

The law requires that the death certificate be executed

Box 68760

P.O. 1

Records.

of Vital

Division

or Attending Physician:

After

Physician

/Medical

Examiner

Funeral

Director

Iteme 23a or 28a-f ehow

Director

by Funeral

Completed

Be

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f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Iteme 23s or 28s-1 ehov other traumatic event, the Medical Examinar must be notified at

with the Maryland

death v

filed within 72 hours after

2 should be fi and Mental H Is marked ot

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun once.

Baltimore, Maryland 21215-0036

Examiner ending physicien and use as the burial-transit by Physician/Medical ò signed by the a Completed page funeral director, Be ٦ 4 hours after dean.

Medical Certification:

Hospitel 24 hours To the Hosp within 24 ho To the Fund completely f State Registrar

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

4 | Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

17995

28a. Date of Injury (Month, Day Year)

Willen as

29c. License number 1280

28c. Injury at Work?

1 □ Yes 2 □ No

М

29d. Date signed (Month, Day, Year) 2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

Other 4 Nursing Home 3 Residence 6 Nother (Specify) Parghter's

28d. Describe how injury occurred

1 Yes

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

31. Date filed (Month, Day, Year) MAY 1 5 2006

11700 Beltsville Dr. Beltsville, MD. Francine Higgs-Shipman, M.D.

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		1 - State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of rtificate of	Health and Death	d Mental H	ygiene Reg. No.	2006	16715
Physic	ian	Decedent's Name (First, Middle, Last					2. Date of D Month	eath Day	Year	3. Time of Death
/Medi		Alzene G	•	Jenkins					2006	6:00 A M
Exami	ner	4a. Facility Name (If not institution, give			4b. City, Town,	or Location of De	eath	4c.	County of Death	
		MEMORIAL HOSPIT 5. Social Security Number 6. Se		(In yrs. last birthday)	CUMI If Under 1 Yea	BERLAND	dre la Data at D		ALLEGANY	
Funeral Director		220-32-4505	ÎM 21√3 F 98		Months Days		8. Date of B lin. Apr 8,	908	9. Birth	place (State or Foreign
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				•	10d. Inside City Limits
Maryl	tor	MD Allegan			perland					1X∏Yes 2 ☐ No
h with the	Funeral Director	10e. Street and Number 217 E. Union St. A	pt. 2		10f. Zip Code	21502		10g. Citiz	zen of What Cou	ntry?
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72 ho	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Deced	dent's Usual Occu	ipation	working	16b. Kir	nd of Business/In	dustry
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filed v Hygie other f	ပိ	17. Father's Name (First, Middle, Last)		Homor	Takoi		Name (First, Middle			
id 2 should be filk ith and Mental Hy 27 is marked oth traumatic event	To Be	W.H. Flowers				Lizzie				
and 2 sh baith and 127 ie m er traum		19a Informant's Name/Relationship (Ty Doris Stewart	Execu	trix ¹⁹ 217	E. Union	St. Apt.	Rural Route Numi Cum	berlar	nd ML	3°21502
Dermit. Pages 1 a Department of Hei mportant: if Item iny Injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donstion 5 ☐ Other (Specify)		20b. Place of Dispo cemetary, crem Scarpelli Fu	sition (Name of matory or other pla neral Hom	e, P.A.	Date 5/22/2006		saptown	
permit. Departm Imports any Inju		21. Signature Funeral Service Licen	hMN	7 / 22	•		Home, PA lue: Cumbe	rland.	MD 21502	
Physician /Medical Examiner bhysicien and ** bhysicien and ** s the burial-transit	dicai Examiner	23a. Part , Enter the disease, or complet of the proof of heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a constitution)	ED PNEUMOI consequence of):						Approximate Interval Between Cnset and Death
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> 10 0	Completed						24a. Was auto perf 1 Yes		24b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	psy findings available npletion of cause of 2 No
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To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, stre (Specify)]Yes 2 □No 	28f. Location (Street and wn, State)	Number or Rura	l Route Number,
To the Hospitel c within 24 hours at To the Funeral D completely filled in	edical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examinate)	sician: To the best of or ner: On the basis of ex and manner state	kamination and/or inv	occurred at the trestigation, in my	ime, date and pla opinion, death oc	ice, and due to the curred at the time,	cause(s) a date and p	and manner as st place, and due to	ated. the cause(s)
omple	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date	signed (Month,	Day, Year)
h->h-0		1/	7		D00	59121		MAY 5		
i i		30. Name and address of person who co	impleted cause of dea	th (Item 23a) (Type, I	Print)				~	
1		DR. TASNEEM MALIK	625 KENT A			UMBERLAN	ND, MARYLA	ND 2	21502	

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2/Dete of Death **Physician** DEAIN 2006 /Medical 4c. County of Death Location of Death 4e Fecility Name (If not institution, give street and number) Examiner GEURGES If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Min. **Funeral** Days Months Hours 1 4 M 2 F ont Yrs Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10b. Gonty 10a. Stete 10c. City, Town or Location ortant: If item 27 is marked other than "natural; or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 THES 2 No Director ON 10e. Street and Numbe 10f. Zip Code 10g. Citizen of Whet Country? 10. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ Ho If Yes, Give Year or Dates: 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ ★16 Specify. Specify: IACK 2 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If feen 27 is marked other than any Injury or other traument. College (1-4or 5+) VONE -NONE 17. Fether's Neme (First, Middle, Last) hformant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City-or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 50 Other (Specify) Release to hospital 21. Signature of Funeral Service Licer CHEVERLY, MD HOSPITAL DRIVE, 23a. Parl . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner attending physician and for use as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? ete has been signed by the a page 2 should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, <u>م</u> 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 No 1 Yes 2 4100 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 100 1 4mpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 27. Menner of Death 28b. Time of Attending To the Hospital or Attending within 24 hours after death.
To the Funeral Director; Afte completely filled in by the fun. 1 Naturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5-9-2006

State Registrar 30. Name and address of person who completed

5 2006

31. Date filed (Month, Dey, Year)

DHMH 16 Rev 6/95

ause of death (Item 23e) (Type, Print)

32. Régistrer's Signature

DR Cheveryms 20181

		-	State of Maryland / Department of Health and N 1 - State Registrer Certificate of Death	/lenta		ene2	006	16717
	g ,		1. Decedent's Name (First, Middle, Last)		e of Death		Vans	3. Time of Death
	Physicia /Medic		GARY L. KESSELL	Ма	_	Day	2006	8:00 P M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death				ounty of Dea	
			9215 Hawkins Creamery Road Gaithersburg			MC	ontgon	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Mo	e of Birth onth, Day, Y		C	thplace (State or Foreign ountry)
ı,	Director	}	218-30-8036 70 7rs. Usual Residence of Decedent	Nov	. 21,	19.	35 Pen	nsylvania
	/land		10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
	Many	to	Maryland Montgomery Gaithersburg					1 ☐ Yes 2 ☐ No
	th the or 284 e not	jre	10e. Street and Number 10f. Zip Code		100	g. Citizer	n of What C	ountry?
	23a	la	9215 Hawkins Creamery Road 20882			U.S.		
	tams tams	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Ye Rican,	s or No- etc.)	14.	Race - Am Black, Whi	erican Indian, te, etc.
2	rs afte	by F	1 Never Married 2 1 Never Married 1 Sec. 1 No Specify: 3 Widowed 4 Divorced Year or Dates:			Sp	ecity: W	nite
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7	d with giene ar tha	Completed	12th Owner/Operator			Hom	e Impi	covements
2	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. All Hygiene. All Chief than "natural", or Itams 23a or 28a-f show event, the Medical Everal or investice notified at	Be (17. Father's Name (First, Middle, Last) 18. Mother's Name	ie (First,	Middle, Ma	aiden Su	ımame)	
7	Ment Marke sarke	၉	Paul G. Kessell Viola		nerman			
0	is m raum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run 111 112 113 114 115 115 115 115 115 115 115 115 115					
ב ע	1 and Healti am 2 ther t		Ella Mae Kessell - Wife 9215 Hawkins Creamery 20a. Method of Disposition 20b. Place of Disposition (Name of	Date				Town, State
2	ages nt of t: If it		1 \text{\text{Mential 2 \to Cremation 3 \to Removal from State}} \\ 1 \text{\text{\text{Tophration}}} \ 5 \to Other (Specify) \\ 1 \text{\text{\text{Tophration}}} \ 5 \to Other (Specify) \\ 1 \text{\text{\text{Tophration}}} \ 5 \to Other (Specify) \\ 1 \text{\text{\text{\text{Tophration}}}} \ 5 \to Other (Specify) \\ 1 \text{\text{\text{\text{\text{Tophration}}}} \ 5 \to Other (Specify) \\ 1 \text{\tex{	3/06	Mc	יחצמי	uria N	faryland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment of the maz's is marked other than "natural, or thams 23a or 28a-f show any injury or other traumatic evant, it a Medical Evantical must be notified at once.							
Ö	Deparent Impo		21. Signature of Funeral Services icenses William 22. Name and Address of Facility Molesworth—William 26401 Ridge Road,	ıs P.	A., I	dne:	ral Ho arvlar	ome nd 20872
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respi	ratory arres	st,	ar y rai	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a CORONAN ALRENT DIS 64	47-				Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):	130				1000
	Examiner		Sequentially list conditions, b.					
	sit ad	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
	and al-trar	Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of):					
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000	ificate g phy as the	0	U.					
ŏ	leath certifica attending ph I for use as th	N/UE	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy			230	d. Date of de	,
0	deat	sicis	In the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)				Month	Day Year
٦ ر	requires that the de een signed by the a nould be detached f	Physician/M	9 Unknown	22	lo Did toba	000 1150	contobute t	o the cause of death?
S,	signed be d	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	20		2 🗆 1		robably 4 📆 Unknown
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e E	rsician: The law is certificate has bi	ldm		24	autopsy	ed?	prior to death?	utopsy findings available completion of cause of
vital	n: Th ficate or, pag	e Co	25. Was case referred to medical 26. Place of Deat			No No	1 🗌 Ye	s 2□ No
=	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes				Other (Spe	acifu)
ō	Phy ral o	\vdash	27. Magner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		scribe how			iony
0	ath. r: Aft	atlo	2 Accident investigation M 1 Yes 2 No					
UIVISION	r Atta er de recto	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Loi Cit	cation (Stre	et and N State)	Number or R	ural Route Number,
	urs aft raf Di lled in	O						
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director After this certific completely filled in by the funeral director,	edical	29a. Certifier Check only (Check only one) 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due rred at th	e to the cau ne time, dat	e and pl	id manner a ace, and du	s stated. e to the cause(s)
	To the within 2 To tha complet	Med	29b. Signaty re and tit le of certifier 29c. License number		290	d. Date s	signed (Mon	th, Day, Year)
	F≥F8				Λ	15.	. 10	2006
	120		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			- 20	<i>,</i> , ,	~ ~
	10		ERICS TANDENBAUM 15225 SHADY GROVERADO #201. ROCKUILLE	MA	SAN TA	D 2	0850	
10	Sta		or. Balo filed (World, Buy, You)		-100			
ĺ	Registr	ar	MAY 15 2006 Bleeve & species					

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State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY **Physician** 2006 LILLIE MAE KENLY 10:30 AM /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 84 213-44-9336 Yrs MARÝLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 Yes 2 ☐ No **MARYLAND** HARFORD **ABERDEEN** Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21001 UNITED STATES 454 WASHINGTON STREET 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK Š 3 XWidowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPER HOTELS 6 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth eny fulury or other traumatic event once. 17. Father's Name (First, Middle, Last) ADA CHRISTY RAYMOND BUCHANAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 898 AVON DRIVE, P.O. BOX 172, ABERDEEN, MD 21001 VIVIAN MISTER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. FERRIS & CO., INC 5/17/06 WEST CHESTER, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hemorrhage intracerebral Physician 24 hrs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? oerformed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 0 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner Death 28d. Describe how injury occurred al or Attending P t after death. I Director: After I d in by the funera After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H55222 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave 501 S. UNION Habr De Grace 32. Registrar's Sign 31. Date filed (Month, Day, Year) State Registrar 2006

			For State	State of Mary		rtment of H			- Z U U D	16719
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	incate of L	Jean	Reg. I	No.	3. Time of Death
	Physicia	an							Day Year 2006	7:15A ^M
	/Medic		Esther L. Kaufman 4a. Facility Name (If not institution, give st.	reet and number)		4b. City, Town, or	Location of Death		4c. County of Deat	
	Examin	er				Doolered	11. MD		Montgo	mo r sz
-	Funeral		1801 E. Jefferson 5. Social Security Number 6. Sex	7. Age (II	yrs. last birthday)	Rockvi If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birt	nery hplace (State or Foreign untry)
h	Director		168-18-2337	M 2 X) F	85 Yrs.	Months Days	Hours Min.	June 16.	1920 Per	nnsylvania
	D		Usual Residence of Decedent	146	S. C. T.					10d. Inside City Limits
	show	_	10a. State 10b. County	10	c. City, Town or Lo	cation				1 X Yes 2 No
	Ba-f	cto	Maryland Montgom	ery	Rockville			100	Citizen of What Co	unto/?
	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow the Madical Exacilier mail be notified at	by Funeral Director	10e. Street and Number			10f. Zip Code		Tog.		unity:
	e 23e	rai	1801 E. Jefferson	St, #203 2. Was Decedent Eve	cin II S 13 V	20850 Was Decedent of Hi	snanic Origin? (Sp.	ectv Yes or No-	USA 14. Race - Ame	rican Indian,
	ftem ftem	Ę.	11. Marital Status 1. Never Married 2. Married 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	Armed Forces?		f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
38	irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give A. Year or Dates:		1□Yes 2√XNo	Specify:		Specify:	White
5-0036	2 hou		15. Decedent's Educ	ation (atom)	16a. Deced	dent's Usual Occupa	ition	ing 16b	. Kind of Business	
215	nin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	9		
N	giene greth	No.	12		Homer	naker			Own Hor	ne
9	al Hygie sother vent, II	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Maid	fen Sumame)	
Vla	should be filed within 72 hours after death with the Marylan and Mental Hygiene. s marked other than atural; or tteme 23a or 28a-f show turnatic event, the Macistel Exactions must be notified at	P_O	Sam Shapiro					Litinsky		
a	and and is mu		19a. Informant's Name/Relationship (Typ	e, Print)	10000000	A ANDROVENIA		al Route Number, Ci		P-0.40
2	and ealth m 27		Linda Hertz/Daugh	ter	1332	Morning	Field Wa	y, Potoma	c, MD 201 Location - City or	Town State
Ore	F its		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. Place of Dispo cemetery, crei	natory or other plac	!			
Ë	tant:		4 □ Donation 5 □ Other (Specify)		Mount Lel		May 1	2, 2006_	Adelphi,	MD
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta important: If item 27 is marked any injury or other traumatic es once.		21. Signature of Funeral Service License	000				nes-Rinald		
	UD = 4 G		23a Part Fotor the disease occomplis	eations that caused the					ver sprii	Approximate
Н			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a c		ertensive	Heart Di	sease		
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	*	ē	Sequentially list conditions, b.	Due to (or as a c	ons quence of:					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ó	en an irial-tr		resulting in death) Last	Due to (or as a c	onsequence of):					
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	Physician/Medical	L d	-						
Õ	ing pt	Med	IF FEMALE:						00 (D ()	
Вох	leath certifi attending I for use as	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth 2[Fetal death 3	Ectopic pregnancy Dther (specify)			23d. Date of de Month	Day Year
	ot the de by the a	ysic	1 ☐ Yes 2 ₹☐ No 9 ☐ Unknown	4☐ Pregnant at tim 9☐ Unknown	ie oi dealii 50					
P.0	thet () ed by detac		Part II. Other significant conditions con	tributing to death but r	not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tobac	co use contribute t	the cause of death?
Records,	law requires thet the as been signed by th 2 should be detache	d by	Multi Infarct Dem	nentia				1 🗌 Yes	2 ∑X No 3 □ P	robably 4 Unknown
Š	w require been si	Completed						24a. Was an	24b. Were a	utopsy findings available
Re	0 - 0						· · · · · · · · · · · · · · · · · · ·	autopsy performed	death?	completion of cause of
Vital	ician: Th certificate ector, pag	0	25. Was case referred to medical	100000			26. Place of Deal	1 ☐ Yes 2 🔀	12.10	
<u>></u>	2 s =	0	examiner? 1 ☐ Yes 2 🙀 No	ospital: 1 🗆 Inpatient	2 ER/Outpatie	nt 3□ DOA Oth	er: 4 🗌 Nursing Ho	ome 51 Residenc	e 6 □Other (Spe	ecify)
0 ر		n; T	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	of 28c. Injur Wor	y at k?	28d. Describe how	injury occurred	
ior	Attending r death.	atic	2 Accident investigation				Yes 2 □No			
Division		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, farm, st (Specify)	reet, factory, office		28f. Location (Stree City or Town, S	it and Number or R State)	ural Route Number,
	ital o			Y. L.					-(-)	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Exemi-	ncian: To the best of each of the basis of each of manner state	xamination and/or in	m occurred at the tire to the	pinion, death occur	red at the time, date	and place, and du	e to the cause(s)
	the ithin 2 or the symple	Mec	29b. Signature and title of centiler	A mainter state	-	29c. Licens	e number	29d.	Date signed (Mon	th, Day, Year)
	To Toon		/////	1			D16/05		May 11,	2006
	2		30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (Type		D16495		riay 11,	2000
			Joel Goozh, MD 64	1			MD 20817			
9	St	ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	Last 8				
	Regist	rar	MAY 12 20	JUD BREWS	1 15 A	430				

06-02938	Please Type or Print	in Black Indelible Ink		
Ann Hessernan Kar			lygiene	005 1670
	1- For State Certificate Registrar	of Death	Reg. No.	006 1672
Physician/ Medical Examiner	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year May 1, 2006	3. Time of Death 0953 hrs
	Facility Name (if not institution, give street and number) Lakeside Drive	4b. City, Town, or Location of Death Greenbelt	Prince G	eorge's
Funeral Director	$\begin{array}{cccccccccccccccccccccccccccccccccccc$	y) If Under 1 Year If Under 24Hr Months Days Hours Mir		9. Birthplace (State or Foreign , DC Washington, DC
nnd show any nce,	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L Maryland Prince George's Greenbe			10d Inside City Limits 1 X Yes 2 No
or 28a-f show fred at once.	10e. Street and Number 107 Lakeside Drive	10f. Zip Code 20770	10g. Citizen of Wh United	· ·

permit. Pages I and 2 should be filed within 72 hours after death with th Department of Health and Mental Hygeries.

Department of Health and Mental Hygeries.

Department of Health and Mental Hygeries.

Department of Health and John House I House Saa, et al. and injury or other tranmatic event, the Medical Examiner must be notified. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black. 2 X Married Armed Forces? White, etc. Never Married 2 X No Yes 1 Yes 2 X No specify. White If Yes, Give Year Specify: Divorced Widowed è 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) own home Baltimore, MD 21215-0036 1-4 Homemaker 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Ann Patricia O'Malley Robert M. Heffernan 19a. Informant's Name/Relationship (Type, Print)
Timothy P. O'Brien -PersonalRep 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6404 Ivy Lane, #400 Greenbelt, Maryland 20770 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a, Method of Disposition

1 Burial 2 Cremation 3 Removal from State crematory or other place)
Gate of Heaven Cemetery5/9/2006 SilverSpring,Maryland Donation 5 Bonalad V. Borgwardt Funeral Home, 21. Signature of Funeral Service 4400 Powder Mill Road Beltsville, Maryland20705 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a Shotgun Wound of Chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician or use as the burial caM-5/11/06 Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day 2 past 12 months? Pregnant at time of death Other (Specify) Yes 2 V No 9 Unknown Unknown by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I as been signed be should be detact à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of this certificate has death? performed' ✔ Yes 2 1 🗸 26.Place of Death (Check only one) 25. Was case referred to medica To the Hospital or Attending Physician: Be Other₄ examiner? DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 FR/Outpatient 3 ٩ 1 V Yes 28a. Date of Injury FOUND: After 1 28b. Time of Injury 28c, Injury at Work? 28d. Describe how injury occurred Manner of Death Certification: FOUND: 9:40an Subject shot self Natural 1 Yes 2 V No within 24 hours after death.

To the Funeral Director: completely filled in by the fi 5 Pending May 1, 2006 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide 6 Could not be or Town, State) determined (Specify) Single Family Home 107 Lakeside Drive, Greenbelt, MD Homicide

29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

29c, License number

O.C.M.E.

May 2, 2006

tame and address of person who completed cause of death (Item 23a)

and title of certifie

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD.

31. Date filed (Month, Day, Year) R gistrar's Signatur State 2008 Registrar

10

29b.

			For State Registrar	State o	f Marylan	d / Depa		of H	ealth a		ental Hyg		006	16721
	Physici: /Medic		1. Decedent's Name (First, Middle Lester W. Kipps	, Last)							2. Date of Dea Month May	Day	2006	3. Time of Death 12:20 A M
	Examin		4a. Fecility Name (If not institution College View	, give street and nui	mber)		4b. City, T		Location o				unty of Death Freder	
	Funeral Director		5. Social Security Number 577-24-6190	6. Sex 1 2 M 2 ☐ F	7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Months	Days	If Under a	Min.	8. Date of Birth (Month, Day May 31	Year)	9. Birth Cou 1 Vir	place (State or Foreign intry) ginia
	ehow	٥٢	Usual Residence of Decedent 10a. State 10b. County West		10c. Cit	y, Town or Lo		7 7						10d. Inside City Limits 1 ☐ Yes 【☐ No
	with the M a or 28a-f	Director	Virgina Berke			Bunk	er Hi				,	•	of What Cou	intry?
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other than "natural, or items 23e or 28e-f ehow enty injury or other traumatic event, the Marical Examination interest and injury or other traumatic event, the Marical Examination in an injury or other traumatic event.	/ Funeral	Broker 11. Marital Status 1 Never Married 2 Marr	12. Was Deci	2 X No			ent of Hi	spanic Orig n, Mexican	jin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White	ican Indian, , etc.
Maryland 21215-0036	in 72 hours "natural", fedicul Exe	Completed by	3 ₹ Widowed 4 □ Divorced 15. Decedent (Specify only highes	's Education it grade completed)	ates:	16a. Deced		Occupa	ition	of workin	ng		of Business/Ir	hite
212 br	illed withi Hygiene. other than	Be Com	Elementary/Secondary (0-12) 4 17. Father's Name (First, Middle,	College (1-4or 5+)	D	airy	Farn	18. Mothe		(First, Middle,		rming	
larylar	2 should by and Menta 1s marked sumatic ex	ToE	Oscar Kipps 19a. Informant's Name/Relations	nip (Type, Print)		19b. Maifir	ng Address	(Street a	nd Numbe	r or Rurai	chouser Route Number lerick,	r, City or To	own, State, Zij	ip Code)
lore, M	iges 1 and it of Health it of Hem 27 or other tr		Barbara Stolz - 20a. Method of Disposition 1 □ Burial 2 ▼Cremation	3 □Removal from	20b. P	lace of Dispo	sition (Nam	e of	a)	Di	ate	20c. Locat	tion - City or T	own, State Maryland
Baltimore,	permit. Pa Departmer Important eny injury once.		4 Donation 5 Other (S		, D	i .	. Name and	Addres	s of Facility	Sta	auffer ike, Fr	Funer	al Hom	e
	Physician		23a. Rart1 Enter the disease or shock, or heart failure. List Immediate Cause (Final	~	1									Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)		or as a conseq	uence of):	ructi	ve	Pu	Imo	napy.	disx	east	
	ate be executed nysician and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	(or as a conseq									
68760,	licate be er physician s the buria	cal		d										
Вох	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	tcome of pregna birth 2 ☐ Feta nant at time of d own	Ideath 3]Ectopic pre] Other (spe					23d	l. Date of deliv Month	very Day Year
rds, P	w requires that been signed b should be deta		Part II. Other significant condition	ens contributing to d	eath but not res	ulting in the u	nderlying ca	use give	en in Part I.			bacco use es 2□N		the cause of death?
Vital Records, P.O.	The law requate has been page 2 should	Completed									24a. Was a autops perfor 1 Yes	SV	24b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available ompletion of cause of
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Magner of Death Natural 5 Pendin	Hospital: 1 🗆		ER/Outpatien 28b. Time of Injury		Othe	17 42 Nu	rsing Hom	(Check only or ne 5 Resided Re	ence 6		ify)
Division of	or Attendi after death. Director: A d in by the fu	Certification:	2 Accident investigned Accident Succide Accident	not be 28e. Place	of fnjury - At he ing, etc. (Specil	ome, farm, str	M eet, factory,		/es 2 □ l		8f. Location (S City or Tow		lumber or Run	ral Route Number,
	ne Hospita n 24 hours ne Funeral	Medical C	29a. Certifier 1X Certifyir (Check only one) Medical	g Physician: To the Examiner: On the b and man	e best of my kno easis of examina ner stated.	wledge, death tion and/or in	n occurred a vestigation,	it the tim	e, date an binion, dea	d place, a	and due to the co	ause(s) an late and pla	d manner as s ace, and due t	stated. to the cause(s)
)	To the within To the comp	Σ	29b. Signature and title of certifie	M	15		29c.	License	604	リフ		5/1	igned (Month,	
	1		30. Name and address of person Hemen Shah 31. Date filed (Manth Osy. Year)	MD .	1650	Thon		Jo	hnse	m]	DV, F	vede	evick	21702 MD
3	Sta Registi	rar	31. Date filed (Month Cay, Year)	2006	legistrar's Sign	or Ap	arti)							

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 1 - State Registres Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 3:15 AM 11, May 2006 William Luther Lochstamphfor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Forest Haven Nursing Home Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Nov 1, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1X M 2□ F 1939 Maryland Director 214-36-4647 66 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County rthan "natural", or itams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21075 USA 6510 Tufts Drive filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify:White Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: If Yes, Give Year or Dates:1957-61 ģ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Finish Carpenter Construction of Heelth and Mental Hygie I Item 27 is marked other r other traumatic event, permit. Pages 1 and 2 should be file.
Department of Heelih and Mental Herimportant: if item 27 is mereny injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel Luther Lochstamphfor Virginia May Wootten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6510 Tufts Drive Elkridge, MD 21075 Terry L. Lochstamphfor/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory | 05/13/06 Beltsville, Maryland 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service bic my e Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CEREBRAL Immediate Cause (Final disease or condition resulting in death) THROMBOSIS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The lew requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical use as ettending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. I signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by ARKINSONS 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No this certificate hes been siral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No or Attending Physician: After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medicai Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death Natural Injury 5 Pending 1 | Yes 2 | No death. investigation s efter death il Director: / id in by the f 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital o within 24 hours aft To the Funeral D completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28595 5/11/06 Inclu HEIGHTS AVE, BALTOMIDELSOS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASNEEM 7220 32. egistrar's Signature 31. Date filed (Month, Day, Year) MAY 15 State 2006 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

06-03284

Merle Richard Lowery

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

2006 | 6723

Certificate of Death Reg. No , Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Medical Examiner Merle Richard Lowery 0758 hrs May 16, 2006 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 12801 Ellerslie Road Cumberland Allegany 5. Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign Country) Days Hours Director 218-38-2350 10/13/1939 66 PA 1 X M 2 F Yrs Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d Inside City Limits Allegany MD Cumberland 1 X Yes 2 No 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12801 Ellerslie Road 21502 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No Race - American Indian, Black, Armed Forces? 1 Never Married 2 X Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes White Yes, Give Year Yes 2 No specify: Widowed Divorce Specify ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Track Department Railroad Baltimore, MD 21215-0036 Я 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Walter E. Lowery Sarah E. DeVore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Lowery/ Wike 12801 Ellerslie Rd., Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Porter Cemetery 5/19/2006 Hyndman. PA Donation 5 Other Specify 21. Signature of Funeral Service 22. Name and Address of Facility Harvey H. Zeigler Funeral Home, Hyndman, PA Physician or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval ailure. List only one cause on each line Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed pur Physician/Medical UNPENDED AMENDED tending physician use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the attending Live birth Fetal death 3 Ectopic pregnancy Month Year 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown detached for Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed by 1 ector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No No 1 🗸 Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical director æ examiner? Hospital: 1 Inpatient 2 Other:4 Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA After this 1 🗸 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 V Natural filled in by the fi 5 Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined Fo the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 17, 2006 10 and address of person who completed cause of death (Item 23a) nas 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) State Registra Q

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TITEM#8 PER FH C856 6/6/06 WS State of Maryland Poepartment of Health and Mental Hygiene 2006 State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day May 5, 2006 Margaret Gray Lynch 5:32P 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Brighton Gardens** Bethesda Montgomery Il Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 🕦 F 80 August 1, 1925 North Carolina 577 26 0123 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 Yes 2000 No Kensington Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20895 4227 Colchester Drive USA 14 Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Clarence Gray Margaret McGowan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert P. Lynch / Husband 4227 Colchester Drive Kensington, Maryland 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 □Donation 5 □ Other (Specify) June 1,2006 Arlington, Virginia Arlington National 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or flear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Leukemia Due to (or as a consequence of): Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

rel', or iteme 23a or 28a-f show Exeminer must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or item eny injury or other traumatic event, the Medical Examiner ange.

Baltimore, Maryland 21215-0036

Direct

Funeral

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Completed

Be ၉

deeth with the Maryland

s been signed be should be detailed

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has

After

within 24 hours after death To the Funeral Director:

To the h

filled in by

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

xaminer Comple Be 2 Certification:

dical	
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □No 9 □ Unknown
by Pr	Part II. Other significant cond
ted by	

art II.	Other significant	t conditions con	tributing to dea	th but not resu	Iting in the und	erlying cause o	iven in Part

	24a. Was an autopsy performed? 1 ☐ Yes 22 N
26. Place of Death (0	Check only one)

		1□ Yes ŽÃN	lo	1 ☐ Yes	2□ No
2	th (C	hack only ona)			
+	lome	5 🗆 Residence	6	□Other (Speci	fy)
	28d.	Describe how inj	ury	occurred	

ı	1 🗌 Yes	2 A No
ı	27. Manner ol	Death
ı	1 ANatura	al 5
ı	2 Accid	ent

3 Suicide

Pending investigation 6 Could not be determined

tal: 1 ☐ Inpatient 2	☐ ER/Outpatient	3 🗆 [AOC	Other:	Nursing I
a. Date ol Injury (Month, Day Year		М		Injury at Work?	2 🗆 No

(World, Day Told)	М	1 Tes	2 🗆 No
28e. Place of Injury - At hon	e, larm, street, fac	tory, office	

4 Homicide	determined	building, etc. (Specify)	m, street, ractor
	V	1	
a. Certifier	1. Certifying Phys	ician: To the best of my knowledge,	death occurred

Hospital:

at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b.	Signature	and	title	ol	certifie
	-	4	Λ	4	

25. Was case referred to medical examiner?

MID

29c. License number D-27 660 29d. Date signed (Month, Day, Year) May 8, 2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24b. Were autopsy findings available prior to completion of cause of death?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alpana Goswami, State

Registrar

Medical

31. Date liled (Month, Day, Year) MAY 12 2006

Der

11119 Rockville Pike Suite #G-100 Rockville, MD 20852

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0

			1 - For State Registrar			tificate of	Death	-	Reg. No.	, 0 0	10160
	Physicia	an	1. Decedent's Name (First, Middle, Last	0				2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic		YONG NYO LEE					May	07	2006	4:35 AM
à	Examin	er	4a. Facility Name (If not institution, give				or Location of Dea	th		nty of Death	
			Baltimore-Washing			Glen H				Arunc	
	Funeral Director		219.17.9987	7. Age (In yrs. la	Yrs.	If Under 1 Yea Months Day		. (Month, Da	th ay, Year) 6, 1924		ace (State or Foreign try) 2.a
	pue *		Usual Residence of Decedent 10a. State 10b. County	10c. City.	, Town or Loc	cation				10	Od. Inside City Limits
	l eho	5	Maryland Anne Arun								1 ☐ Yes 21 No
	28a-1	Directo	10e. Street and Number	det pev	ern	10f. Zip Code			10a Citizan	of What Count	2012
	3a or	iDir	8201 Clearwater (Court		21144			Kore		try :
	deatl	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	S. 13. V		Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No	o- 14. F	lace - America	
036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene important: if Item 27 is marked other then "naturel", or Iteme 23s or 28s-f show minipror or the traumattic event, the Madical Examinar must be notified at appec.	Ď	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Yes 22N		no Hican, etc.)	i i	llack, White, e	
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\geq	Physician: this certitional director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient	t 35 DOA	Mark a se	Home 5 ☐ Resi		Other (Specify)
o uo	te in		27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of Injury	28c. In		28d. Describe			,
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely tilled in by the to	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		eet, factory, offic	е		Street and Nu wn, State)	mber or Rural	Route Number,
	ne Hospli n 24 hour ne Funera	edicai (29a. Certifier 1 ⊠ Certifying Phy (Check only 2 ☐ Medical Examone)	ysician: To the best of my know niner: On the basis of examinati and manner stated.	viedge, death ion and/or inv	occurred at the restigation, in my	lime, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)
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	3		1	147		D-2	5654		Mav 1	0, 200	6
	~		30. Name and address of person who o	completed cause of death (Item	23а) (Туре, І						
			Yeong Oh, MD, 14	12 Crain Highw	ay Nor	th, Sui	te #6-A,	Glen Bu	rnie, M	lary1an	d 21061
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 2 2	32 Registrar's Signat	hie hie	arte					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month May 12^{Bay} 2006 **Physician** 4:00pM Norman E. Lauer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville National Lutheran Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 21, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Washington 82 Director 518-16-8612 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a, State 10b. County of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic avent, if a Medical Exemples must be nutliked. 1 ☐ Yes 2 No VA Arlington Arlington Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22201 USA 1008 N. Daniel Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠ Yes 2 □ No If Yes, Give 42-45 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White ģ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US Government Elementary/Secondary (0-12) College (1-4or 5+) 12 Dept. of Justice 5+ Chief. Appraisal Section 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis Fredrick Lauer Anna Delores Gerding 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1008 N. Daniel St., Arlington, VA 22201 Eleanor L. Lauer-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 5/20/06 4 □ Donation 5 □ Other (Specify) Columbia Gardens Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Murphy FH 4510 Wilson Blvd, Arlington, VA 22203 Part1. Poler the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 🗌 Yes 2 **HN**6 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? page 2 1 No 1 ☐ Yes Hospitel or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 2 1 Yes 2 5 10 1 | Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? iuneral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; After Injury 5 Pending 1 Hatural after death.

I Diractor: Af
d in by the fur 1 🗌 Yes 2 🗌 No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours a To the Funerel I 1D certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signarure and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles W. Karesh National Lutheran Home 9701 Viers Dr. Rockville, MD 31. Date filed (Month, Day, Year) MAY 1 6 2006 Registrar

	Pe .		1 - State Amend Item	State of Ma 28b per	ME,G8	/ Depa 55 _0	artment of 125/06	of Health Deati	and M h	lental F	lygie Reg	ne 2 []	06	16	727
	ly Discontinu		1. Decedent's Name (First, Middle, Last)							2. Date of Month	Death	Day	V	3. Time of	Death
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	Examir		4a. Facility Name (If not institution, give s	treet and number)			4b. City, To	wn, or Location	n of Death			4c. County of	of Death		
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ij,	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last		If Under 1 Y Months D	ear If Under ays Hours	er 24 Hrs. Min.	8. Date of (Month,	Birth <i>Day, Y</i>	ear)	Cou	place (State of ntry)	
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	ms 2	Funerai		12. Was Decedent B	Ever in U.S.	13. \	Was Deceden	of Hispanic C	Origin? (Spe	ecify Yes or	No-	USA 14 Race		can Indian.	
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2	72 hours after death with the Maryland 'naturel', or Items 23s or 28s-f ehow diest Exboliner count be notified at	Completed	15. Decedent's Educ (Specify only highest grade		1		dent's Usual C		nst of worki	na	16	b. Kind of Bus	siness/In	dustry	
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<u>a</u>	2 sh and is m		19a. Informant's Name/Relationship (Type				ng Address (Si						State, Zip	Code)	
d)	and leelth im 27 her t		Rosalee Browne Lea	ach/wife	LOOK DIS		72 Box								
Ö	t of h		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re	emoval from State	ceme	etery, crer	sition (Name on natory or other	r place)		ate	20	c. Location - (City or To	own, State	
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Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should b Deperment of Heelih and Menta important; If item 27 is marked eny injury or other traumatic energe.		21. Signature of Funeral Service License	MU	1.	Scha	. Name and A effer F	ddress of Fac H II N. I	^{llity} Scar Main St	pelli Pete	Fu	neral :	Home 6847	, P.A.	for
H	Physician and /Medical Examiner step private the private step private	dical Examiner	23a, Party Enter the disease, or comblishook, or heart failure. List only on timmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause, Disease or injury that indiated events resulting in death) Last	Due to (or as a	consequent	ce of):								Interval Betwonset and D	
)	the death certi y the attending iched for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	ath 3□]Ectopic pregn] Other (specif					23d. Date Mont		ary Day	ear
Hecords, P.	ng eq	ρ	Part II. Other significant conditions con	tributing to death bu	ıt not resultin	g in the ur	nderfying caus	e given in Pari	11.				oute to the	ne cause of de pably 4 ∐U	eath? nknown
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or vital	tending Physicien; leath. tor: After this certific the funeral director,	To B	examiner?	ospital:	ot 2 DED	Outpation	t 3 DOA	Other		Check on	- 37				
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5	efte Diri	Certification;	4 Homicide	Homo, etc	. (Specify)				V	City or 1	own, S	State)	11:00	0 2/1/	
	To the Hospital or Al within 24 hours effer of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Exemin	ician: To the best o	examination	dge, death and/or inv	occurred at the	ne time, date a my opinion, de	and place, a eath occurre	and due to the	e, date	e(s) and man and place, ar	ner as sind due to	lated. the cause(s)	
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	0		30. Name and address of person who con					AND 300	0.1						
	Sta		DR MICHAEL STASKO 31. Date filed (Month, Day, Year)	924 SETC)N DKI. ır's Signature		OMBEKL	AND, MD	21:	502		_	-	-	
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State of Maryland / Department of Health and Mental Hygiene 🗍 🛭 🖯 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** May 4, 2006 6:30 РМ Mildred Kelber Leifer /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 02/06/1920 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 ☐ M 2 🟋 F 86 Director 390-12-6366 Wisconsin Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar count be notified at 1 Yes 2 □ No by Funeral Director Bowie Maryland Prince Georges 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? 20715 USA 3006 Traymore Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2[X]No fYes.Give 1 ☐ Never Married 2 🛛 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Heelth and Mental Hygiene. ant: If Item 27 is marked other than ury or other traumatic event, Ita Ma Elementary/Secondary (0-12) College (1-4or 5+) Assistant Office Manager Manufacturing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louisa Bandlow Frederick Kelber, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3006 Traymore Lane Bowie, MD 20715 Leroy R. Leifer/ Husband 20b. Place of Disposition (Name of cometery, crematory or other place)
Maryland
Veterans Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or 4 ☐ Donation 5 ☐ Other (Specify) 05/09/2006 Crownsville, MD 21. Signature of Funeral Service Licegsee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** oronore a 8 disease or condition resulting in death) /Medical Due to (or as a co uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: anding physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical ettending p IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of deliver 3 Ectopic pregnancy in the past 12 months?
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9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown ል Other significant conditions/contributing to death but not resulting in the underlying cause given in Part I. ete hes been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 XNo 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 2 No certificate 1 ☐ Yes Division of Vital Hospital or Attending Physician: After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending efter death. 1 □ Yes 2 □ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of ceptifi 29c. License number 29d. Date signed (Month, Day, Year) Crain Myhway Sw Glin Burne MD 21061 of rson who completed cause death (Item 23a) (Type, Print) 30. Name and address ichu 208

DHMH 17 Rev 1/2001

State

Registrar

31. Date III

1 0 2006

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MCDUNNELL Month Day Vear **Physician** 21,57 VICKI ANN May 10 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MAryland Medical Conter Baltimore of University If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Months 215-64-1596 Director 50 09-20-55 Marvland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "naturel", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1708 Country Court 21702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2⊠No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. ant: If item 27 is marked other than Lry or other traumatic event, use Ms Elementary/Secondary (0-12) College (1-4or 5+) 12 Financial Clerk Health Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles K. Turner Barbara Wiles Salt ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chris Turner / Brother 1609 White Wing Circle, Friendswood, Texas 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department if important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory | 5-13-06 Smithsburg, Maryland 22. Name and Address of Facility Robt. E. Dailey & Son F. H. 1201 North Market Street, Frederick, MD. 21701. A. 21. Signature of Funeral Service Licen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tachycas dia Ventricular **Physician** MING to S /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) ned by the a e detached f 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signe should be c δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t autopsy performed? 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospitai 1th.Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P19782 11 2006 May IsmMaci MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET Ba Himore, Mory lost # 2304 CHARLES ALSON MERCURIUS 218 NORTH 31. Date filed (Month, Day, Year) Registrar's Signature State 2006 MAY 15 Registrar

Please Type or Print in Black Indelible Ink Matthew Brown McConnell State of Maryland / Department of Health and Mental Hygiene 2006 16730 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day May 18, 2006 Medical Examiner Matthew Brown McConnell 0920 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Route 273 and Little Elk Creek Road Elkton Cecil 5 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Director Min 221-24-8923 75 Country)Scotland 1X м NOV 12, 1930 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No show Maryland E1kton Ceci1 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 23a or 2 105 Perth Lane 21921 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? Never Married 2 X Married White, etc. 2 X No Yes Widowed Divorced f Yes, Give Year 1 Yes 2 X No specify: Specify: ੬ White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) i Mental Hygiene. marked other than "i ic event, the Medical E Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. MD 21215-0036 Self-Employed Scottish Imports 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be item 27 is marked traumatic event, Matthew Brown McConnell Jeanie Russell Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret C. McConnell/Wife 105 Perth Lane, Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, permit. Pages I and 20c. Location - City or Town, State May Gracelawn Memorial Park 1 X Burial 2 Cremation 3 Important: injury or oth 2006 New Castle, Delaware 4 Donation 5 Other Specify 22 Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licenses Maryland Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Between Onset and /Medical Death a. Ruptured Abdominal Aortic Aneurysm Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ending physician use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 3 Ectopic pregnancy Day 2 Fetal death Month Year Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Other₄ Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 Other: Scene this FR/Outpatient 3 DOA 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: ✓ Natural

after death.

Director: A in by the fi within To the

Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 19, 2006

28e. Place of Injury - At home, farm, street, factory, office building, etc

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City

30. Name and address of person who completed cause of death (Item 23a)

5 Pending

Investigation

Could not be

Patricia Aronica-Pollak MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State Registrar

Accident

Suicide

Medical

B2. Registrar's Signature

		State of Maryland / Dep	partment of Health and Mental Hy	
		Decedent's Name (First, Middle, Last)	2. Date of D	eath 3. Time of Death
Phys /Me	ician dical	I long logone Madales	Month Mav	10,2006 12:10P ^M
Exan		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		Calvert Memorial Hospital	Prince Frederick	Calvert
Funer		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. 8. Date of B Months Days Hours Min. (Month, D	irth 9. Birthplace (State or Foreign Country)
Directo	or	Usual Residence of Decedent	December	c 11,1936 New York
land ow		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
Mary I-f sh	ţ	MD St. Mary's Charlot	tte Hall	1 ☐ Yes 🏋 No
h the	irec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
at yielild Z.I.Z.I.3-0030 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Expriment in instituted at	Funeral Director	29449 Charlotte Hall Road	20622	USA
ams s	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
affe a	II.		1 ☐ Yes ZX No Specify:	
ural',	þ	3 Widowed 4 Divorced Year or Dates:		WIIICE
"nat	Completed	15. Decedent's Education 16a. Decedent's Education (Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
withii ene. than	8	Elementary/Secondary (0-12) College (1-4or 5+)	· ·	
filed Hygir sht.	Ö		teamfitter 18. Mother's Name (First, Middle	Union a. Maiden Sumame)
d be antal	To Be	1 - 1 - 1	Elizabeth M	,
Shoul od Ma mari	1	·	ling Address (Street and Number or Rural Route Numi	
Defitition (e), Intel yield A I Z I 3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar loopstrand of Health and Mandail Hygiens. Important: I flem 21 as marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at			36 Ocean Pkwy, Berlin	
S 1 au item othe		20a. Method of Disposition 20b. Place of Disp	osition (Name of Date amatory or other place)	20c. Location - City or Town, State
Dallillor Dermit, Pages Department of mportant: If it		1 Burial 2 Cremation 3 Removal from State Brinsfi	Leld-Echols 5/13/06 (harlotte Hall MD
mit, partm sorta / inju	ej l	21. Signature of Funeral Service Licensee, M00945	Name and Address of Facility	narrocce narr, mb
D POE	ouce	Havr C. Echuls	AREHART - ECHOLS FUNER	AL HOME, P.A
Wat !		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory	Approximate Approximate
Physicia	n			Onset and Death
/Medica	al	resulting in death) a Due to (or as a consequence of):	spiratory Failure	
Examine	er	Aspiration	Preumonia	
P =	Je L	Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
ocuted nd transi	Examiner	Cause (Disease or injury that initiated events c.		
e exe				
of oU, sate be executed physician and the burial-transit	Cal			
to the death certification by the attending phase for use as t	Physician/Med	IF FEMALE:		
ath cer tendir or use	an/	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy	23d. Date of delivery
e des the at	S	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 ☐	Other (specify)	Month Day Year
d by	A d	Pod II Other significant conditions contributing to death but not resulting in the	. d. 1	
res that signed b	þ	Part II. Other significant conditions contributing to death but not resulting in the i		tobacco use contribute to the cause of death?
w requires to been signed should be	ompleted	Houte Kenal Failure, Br	ain Stem G.V. 17 10	Yes 2 No 3 Probably 4 Unknown
a law has b	alau	Cirrhosis DF Liver.	24a. Wa:	psy prior to completion of cause of
The The cate I page	Co	Congestive Heart Failure,	perf 1 ☐ Yes	ormed? death? 2 ☑ No 1 ☐ Yes 2 ☐ No
ding Physician: The law h.c. After this certificate has b funeral director, page 2.5	Be	examiner?	26. Place of Death (Check only	
Physic this c	2	The state of the s		
ding Phys	on:	r 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury (Month, Day Year)	Work?	how injury occurred
thend death ttor:	cat	2 Accident investigation 3 Suicide 6 Could not be 380 Place of Injury. At home form of	M 1 Yes 2 No	
or Al	Certification:	4 Homicide determined 289. Place of Injury - At home, farm, si building, etc. (Specify)		(Street and Number or Rural Route Number, wn, State)
pital purs a eral filled				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attending Physician: The law requires that the death certificate be executed within 24 hours attended that the total biractor: Attent this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at the time	dause(s) and manner as stated. date and place, and due to the cause(s)
o the o the o the	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
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discontinue .	State	31. Date filed (Month, Day, Year) 32. Projectrar's Signature	1	11.00 00131
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Physic		Decedent's Name (First, Middle, Last, Edward L. Milhend		-				2. Date of Dea Month	th Day	Year	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give	street and number)			Town, or Location		May 8,	2006 4c. County		5:00A
Funeral Director		1801 E. Jefferson 5. Social Security Number 6. Security Number 029-09-9221 Usual Residence of Decedent		93 Yrs.	If Under	Ockvill 1 Year If Und Days Hour	der 24 Hrs.	8. Date of Birth (Month, Day Oct 1,	1	gomer 9. Birthpl Count Be1g	ace (State or Foreigns)
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental hygiene. Importent: If Item 27 is marked other than "natural", or items 23e or 28e-f show any origin or other traumatic event, the Medical Examinar must be rotified at ance.	Funeral Director	10a. State 10b. County Maryland Montgon 10e. Street and Number 1801 E. Jefferson 11. Marital Status	nery R 1 St. #641 12. Was Decedent Ever in L Armed Forces?	ockvill	10f. Zip 0	852	Origin? (Si	pecify Yes or No-			an Indian,
ad within 72 hours aft giene. er than "natural", or ithe Medical Exem	b	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu. (Specify only highest grade		16a. Deced	kind of work	Occupation		king	Specify		White ustry
d be filed withir notal Hygiene.	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+) 5+		iness	Owner 18. Mo		ne (First, Middle, I		Emp	loyed
1 and 2 should be file Health and Mental Hy om 27 is marked oth ther traumatic event	To	Unobtainable 19a. Informant's Name/Relationship (Ty, Judith Shulman/Da 20a. Method of Disposition	ughter	2843	Allen	(Street and Num dale_P1	nber or Ru	ainable ral Route Number Washin		200	08
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death certificate be executed Wedical Examine e eltending physicien and of for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, ox complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	Pnuemon quence of): Non Hod quence of).	ia	Lympho		or respiratory arri	est,		Approximate Interval Between Onset and Death 2 mos
death certif e ettending id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c	I death 3 🗌	Ectopic pre Other (spec				23d. Date Mon	of deliven	y Day Year
requires the been signed should be de	Ď	Part II. Other significant conditions con Coronary Artery D		ulting in the un	derlying cau	use given in Pai	rt I.	1 □ Ye	s 2 No	3 🗌 Probal	cause of death?
	Be Completed	25. Was case referred to medical	-			26 Pla	ice of Deat	24a. Was ar autops perform 1 Yes 2	y pi ned? di 以No 1	rior to comp eath?	sy findings available pletion of cause of
S S D	Certification; To E	examiner? 1 Yes 2 No H 27. Many of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	286 M	c. Injury at Work?	Nursing Ho	ome 5 Reside 28d. Describe ho	nce 6 □Othe w injury occurre	ed	
To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral	edical Certifi	4 ☐ Homicide determined 29a. Certifier 1 ☑ Certifying Phys	28e. Place of Injury - At h building, etc. (Specifician: To the best of my knoer: On the basis of examina	y)	occurred at	the time date	and place,	28f. Location (Str. City or Town and due to the ca	, State)	nor ac etal	tod.
To the h within 24 To the F complete	Med	one) 29b. Signature and title of certifier	and manner stated.	and and of the		License numbe			and place, and place,		
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No... 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 Physician 8, 8:15 P. M Beverly Mary Henry Murray May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 1538 Addison Road South Prince Georges District Heights If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | (Month, Day, Year) 1950 | 9. Birthplace (State or Foreign (Month, Day, Year) 1950 | 9. Birthplace (State or Foreign (Month, Day, Year) 1950 | 9. Birthplace (State or Foreign (Month, Day, Year) 1950 | 9. Birthplace (State or Foreign (Month, Day, Year) 1950 | 9. Birthplace (State or Foreign (Month, Day, Year) 1950 | 9. Birthplace (State or Foreign (Month, Day, Year) 1950 | 9. Birthplace (State or Foreign (Month, Day, Year) 1950 | 9. 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Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No ff Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Itams 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced *neturel', Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S.Dept. of Navy/Naval Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other then " ary or other traumatic event, the Ma. College (1-4or 5+) Elementary/Secondary (0-12) Research Laboratory Support Technician 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James Osbin Henry Rosetta Montaque 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 19a. fnformant's Name/Relationship (Type, Print) 1538 Addison Road South; District Heights, Maryland Jerry Murray, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 13, 2006 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny injury or National Harmony Memorial Park Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Summer of Funeral Service Licensee R.N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) Physician Leiomyosarcoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 4 Pregnant at time of death ed by the a 1 ☐ Yes 2 X No 9 Unknown signed d be det Part ff, Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peeu 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate After this certification funeral director, I Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 X No 4 Nursing Home 5X Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 XNatural 5 Pending s after death. 1 Yes 2 No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide ò 24 hours 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie To the Hosp within 24 hor To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and fitty of certifier 29c. License number 29d. Date signed (Month, Day, Year) D29142 11, 2006 ece 1mo 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 20902 Charles R. Boice, M.D.; 10301 Georgia Avenue; Suite 205 West; Silver Spring, Maryland 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAY 1 6 2006 Registrar

DHMH 17 Rev 1/2001

	سي	1	State Registrar Decedent's Name (First, Middle,	[ast]			Ce	rtificat	te of	Death		2. Date of			to the little	3. Time	of Death
Physici	an	ľ	Barbara	_	1.	Ma	rcotte						1, 200	3	Year	7:15	A
/Media		46	e. Fecility Name (If not institution,	give st	reet and numb	per)		4b. City,	, Town, o	or Location of		-		County	of Deat	h	
LXaiiiii	ICI	١.	Ft. Washington Heal	th 8	Rehah.	Center		Ft.	Wash	ington			Pı	rince	Geor	ge's	
uneral irector		5.	Social Security Number 508–14–9107	6. Sex	M 2403(F)	. Age <i>(In yr</i> s. 84	last birthday) Yrs.		r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of (Month June 1	Birth <i>Day, Year)</i> 7 , 192	L	9. Birt Co	hplace (Sta untry) Minn	te or Fore esota
>		-	Isual Residence of Decedent Oa. State 10b. County			too Ci	ity, Town or L	ncation								10d. Inside	City Lim
eho m	č		aryland Prince	Coor	rao i s		Washin										es 2,100
28a-1	rect	11	0e. Street and Number	0001	.gc 3	10.	· Wasini,		p Code				10g. Cit	izen of W	/hat Co	untry?	
38 of	Ö		12021 Livingston R	Road					2074	4				USA			
E LE	ner	1	1. Marital Status	1	2. Was Deced Armed Forg	ent Ever in U	J.S. 13.	Was Dece	edent of h	Hispanic Ori an, Mexicar	gin? (Spec	rify Yes or	No-		e - Ame	nican Indian	,
Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show eny injury or othar traumatic event, <u>tra Medical Examinar must be redified at</u> <u>once.</u>	by Funeral Director		1 Never Married 2 Married 3 Widowed 4 Divorced		1 ☐ Yes 2 If Yes, Give Year or Dat	Ø No		1 ☐ Yes						Specify			
Silve Si Silve Si Silve Silve Silve Si Silve Silve Si Silve Si Si Silve Si Si Si Si Si Si Si Si Si Si Si Si Si	edt	-	15. Decedent's	s Educ	ation		16a. Dece	dent's Usu	ual Occup	pation			16b. K	ind of Bu	siness/	Industry	
other than "na ent, the Medic	piet	\vdash	(Specify only highest Elementary/Secondary (0-12)	grade	College (1-4	4or 5+)			ork done use retire	during mos	t of workin	g			_		
er tha	Completed		12				CI	erk								nment	
d oth	Be		7. Father's Name (First, Middle, L										dle, Maider	Sumam	Θ)		
narke	2	-	Oscar Marcotte		- Direct		105 14-11	- A dd	- /Ctana	Ze.	lla Zee		mbas Cibs	Taum	Ctata	Zin Cadal	
tem 27 is mother trauma		1	19a. Informant's Name/Relationshi Harry S. Bultman /		e, Pnnt)			,		Drive						20744	
tem 2 other			0a. Method of Disposition	5011		20b.	Place of Disponentery, cre					ite ite	-			Town, State	
y or c			1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		moval from S	Kal	tas Crem	atory	otner pia	0	5/13/2	006	Edgev	ater,	Mar	yland	
injur		2	21. Signature of Funeral Service L		θ/	/	2	2. Name a	and Addre	ess of Facili	y Geo:	rge P.	Kalas	Funei	ral I	lome P.	A.
Important: If if eny injury or o once.			Son 8.K	al	as 1	7	6	160 Ox	on Hi	ill Roa	d Oxon	Hill,	Maryla	and	2074	4 5	
edical miner		1	resulting in death)		Due to to				<i>(</i>) <i>(</i>								$\nu \nu \nu$
sician and burial-transit	al Examiner	1	Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events resulting in death) Last	b.	Due to (o	r as a consecutive as a	quence of):	ne			dis	re .				51	アケ
g physician and as the burial-transit	cal		Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. c.		de	ine	nle	i.		e	·				51	アア
the attending physician and ched for use as the burial-transit	cal		Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes XX No	b. c. d.	Due to (o	ome of pregn	quence of):	pl)	er-	· e		23d. Dat Mor		5 I	Year
signed by the attending physician and it is the detached for use as the burial-transit	by Physician/Medical	F	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2⊠No		Due to (o	ome of pregn th 2 Fet nt at time of	quence of): mancy el death 3 death 5 death 5	Other (s	specify)_	y Sy		23e. D	id tobacco	Mor	nth ribute to		of death?
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ate has been signed by the page 2 should be detached	To Be Completed by Physician/Medical	F	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ns con	Due to (o	ome of pregnoth 2 Fet nt at time of wn ath but not respect to the patient 2	quence of): nancy el death 3 death 5 (sulting in the of):	Other (s	cause gi	ven in Part l	e of Death	23e. D 1 24a. W p 1	id tobacco Yes 2 As an attopsy aftermed? \$200 No. (y one) esidence	Moruse contr	onth Tibute to 3 Pr Were autorior to death? Yes	Day The cause obably 4 utopsy finding completion 2 No	of death?
After this certificate has been signed by the funeral director, page 2 should be detached	To Be Completed by Physician/Medical	F	Part II. Other significant condition 25. Was case referred to medical examiner? 1 □ Yes 2 ⋈ No 27. Manner of Death 1 ☒ Natural 5 □ Pending	H g	Due to (o	ome of pregnoth 2 Fet nt at time of wn ath but not respect to the patient 2	quence of): mancy el death 3 death 5 (sulting in the of	Other (s	cause gr	26. Place	e of Death ursing Hom	23e. D 1 24a. W p 1	id tobacco Yes 2 As an itopsy artormed? s 2\overline{\text{2}}\text{No.}	Moruse contr	onth Tibute to 3 Pr Were autorior to death? Yes	Day The cause obably 4 utopsy finding completion 2 No	of death?
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After this certificate has been signed by the funeral director, page 2 should be detached	Certification; To Be Completed by Physician/Medical	F	PERMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes XXINO 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 XINatural 5 Pending investig 3 Suicide 6 Could not determine	H H g jation not be ined	Due to (or Due to (or	patient 2 Injury, Athg, etc. (Spec	quence of): nancy el death 3 ideath 5	other (s	cause gr	26. Place ther: 4XN Number 2	e of Death ursing Hom 2: No 2	23e. D 1 24a. W au py 1 Ye (Check on the 5 R 8d. Descrit 8f. Locatio City or	id tobacco Yes 2 Yes an stopsy And Stope And S	Moruse control No 24b. V 6 Other nod Number and Number) and ma	nth 3 Pr Were au orior to departh? Yes er (Special Pr ed	Day Day Dilhe cause robably 4 utopsy findir completion 2 No cify)	of death* Unknown gs availa of cause
After this certificate has been signed by the funeral director, page 2 should be detached	To Be Completed by Physician/Medical	F 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	H H g jation not be ined	Due to (or Due to (or	patient 2 Injury, Athg, etc. (Spec	quence of): nancy el death 3 ideath 5	other (s	cause gri	26. Place her: 4\forall Number opinion, dear opinion, dear see number	e of Death ursing Hom 2: No 2 and place, and th occurre	23e. D 1 24a. W au py 1 Ye (Check on the 5 R 8d. Descrit 8f. Locatio City or	id tobacco Yes 2 As an anotopsy anormad? s 202 No ly one) esidence be how inju n (Street au Town, State the cause(s ne, date an	Moruse control No 24b. V 6 Other 7 occurr 1 d Number 1) and ma	ibute to 3 Pr Were au Orleicath? Pressent (Speed ed Pr or Ru	Day Day Dilhe cause robably 4 utopsy findir completion 2 No cify)	of death? Unknowngs available cause
ate has been signed by the page 2 should be detached	Certification; To Be Completed by Physician/Medical	F 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes	H H g jation not be ined	Due to (or Due to (or	patient 2 Injury, Athg, etc. (Spec	quence of): nancy el death 3 ideath 5	other (s	cause gri	26. Place her: 4\forall Number opinion, dear opinion, dear see number	e of Death ursing Hom 2: No 2	23e. D 1 24a. W au py 1 Ye (Check on the 5 R 8d. Descrit 8f. Locatio City or	id tobacco Yes 2 As an anotopsy anormad? s 202 No ly one) esidence be how inju n (Street au Town, State the cause(s ne, date an	Moruse control No 24b. V 6 Other 7 occurr 1 d Number 1) and ma	ibute to 3 Pr Were au Orleicath? Pressent (Speed ed Pr or Ru	Day Day Day Day Day Day Day Day	of death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death MAY 4, 2006 0042 AM EASTER MITCHELL 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 4 - 20 - 19 3 7 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) WADESBORO, NO 1 ☐ M 2√2 F 69 Yrs. 240-64-4935 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No PRINCE GEORGE'S SUITLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES

20746

(Give kind of work done during most of working life. DO NOT use retired)

1 ☐ Yes 2 No Specify:

16a Decedent's Usual Occupation

FOOD SERVER

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14 Race - American Indian. Black, White, etc.

20745

Approximate Interval Between Onset and Death

INC

Specify: BLACK

16b. Kind of Business/Industry

Month

Day

1 ☐ Yes 2 No

06

20746

Year

FOOD

18. Mother's Name (First, Middle, Maiden Sumame)

GEANNIE TILLMAN

death with the Maryland r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 2 should be filed within 72 hours after a and Mental Hygiene. Baltimore, Maryland 21215-0036 1 and 2 s of Health ar permit. Pages 1
Department of H
Importent: If ites
any injury or ott

Physician

Examiner

/ Funeral

Director

/Medical

MD

4808 MEDORA DR.

15. Decedent's Education (Specify only highest grade completed)

JAMES THOMAS GAINEY

1 Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

12th

. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:

College (1-4or 5+)

Funeral Director

þ

Completed

Physician /Medical Examiner

Examiner certificate be executed burial-transit attending physician Physician/Medical use as the signed by the þ Completed Be Certification: death. after death Director:

P.O. Box 68760 Division of Vital Records, Hospital or Attending Physician: filled in by 24 hours a To the Vithin 2

19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4910 WEALDING WAY, OXON HILL, MD. RONALD MITCHELL/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -11-06 CEDAR HILL CEMETERY SUITLAND, MD CAPITOL MORTUARY 22. Name and Address of Facility 21. Signature of Funeral Service Openser 1425 MARYLAND AVE., N.E. WDC 20002 complications that caused the death. 23a. Part 1. Enter the disease or shock, or heart failure. List o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? (es 2.24No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🏋 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Naturai 5 Pending Injury 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier I 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie DOOJ1194 30. Name and address of person and completed cause of death (Item 23a) (Type, Print) EMERSON CORONEL MD 5001 SILVER HILL, RD #101 SUITLAND, MD.

DHMH 17 Rev 1/2001

Medical

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 5 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 121591 2006 Mas Luisa Delgado Montano /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville
If Under 1 Year If Under 24 Hrs. Montgomery 8. Date of Birth (Month, Day, Year)
Dec. 31, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□M 2∰F Months Days Hours 577-58-0451 79 1926 Cuba Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Iteme 23a or 28a-f ehov il Hygiene. other then "netural", or Iteme 23a or 28a-f ehov vent, Itta Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Maryland Montgomery Germantown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19614 Crystal Rock Drive #13 20874 U.S.A. Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 □Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 X Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 ☐ Divorced Cuban White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth any lighty or other traumatic event 9DEB. Be ဥ Luciano Delgado Dolores Mas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20882 7408 Planters Lane, Gaithersburg, Maryland Iliana Ortiz - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Onestion 5 ☐ Other (Specify) 5/15/06 Silver Spring, Maryland Gate of Heaven Cemetery 21. Sign ture of Juneral Sector Licen 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home Ever 20872 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final bdominal VISTUS Days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events attending physicien and resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ Ho
9 ☐ Unknown Day 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Mo 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 2 No 24b. Were autopsy findings available prior to completion of cause of 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Tyes 2 No 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending within 24 hours after deeth.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

MAY 15 2006

31. Date filed (Month, Day, Year)

S- CHANALES

SVS SHAROY

Registrar's Signature

Rever St Specific

State

GROVE RD ROCKVICLE MD

State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** May 11, 8:20 A M 2006 Mary Catherine Mussman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5498 Huckleberry Drive Charles Bryantown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State Country) | March 15, 1930 | Mary 1 and 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 76 218-24-3021 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other then "natural", or itema 23a or 28a-1 shov other treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Directo Maryland Charles Bryantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5498 Huckleberry drive 20617 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ (No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary IRS permit. Pages 1 and 2 should be file Department of Heath and Mental Hy, Importent: If item 27 is marked other any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Elsie Thompson Joseph Norman Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 402, Bryantown, MD 20617 Lester B. Mussman - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 5-15-2006 Bryantown, MD 4 ☐ Donation 5 ☐ Other (Specify) M00053 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3035 Old Washington Road LY. POB 156, Waldorf, MD 20604 Deheum Huntt Funeral Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No this certificate 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ဂ္ 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of centier 29c. License number 29d. Date signed (Month, Dey, Year) 00091031 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Michael A. Leatherwood, 12070 Old Line Ctr., #302, Waldorf, MD 20602 31. Date filed (Month, Day, Year) egistrar's Signature 32 State MAY 12 2006

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			For Stata Registrar	State of Ma	aryland				ealth a Death	ind M		giene Reg. No.	200	6	167	38
	Dhysiai	200	1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month	Day	Q Q Q Ye	ar	3. Time of	
	Physici /Medic		Alice Virginia Mye								Month May	9	2006		1904	РМ
	Examin	er	4a. Facility Name (If not institution, give s						Location o				County of [
34			Holy Cross Hospita 5. Social Security Number 6. Sex		e /In vrs Is	ast birthday)		ver 1 Year	Sprin		8. Date of Birt	th.	ontgo			r Foreian
	Funeral Director			M OFF	31	Yrs.	Months		Hours	Min.	(Month, Da 10/26/	1924	V	Coun irg	lace (State or try) inia	, o. o.g.,
			Usual Residence of Decedent		,											
	nylan Ihow		10a. State 10b. County		,	, Town or Lo								10	0d. Inside Cit 1 ☐ Yes	
	Ba-f a	cto	Maryland Montgomer	У	Silv	ver Sp						10 000	/ 1 h m			ZA NO
	or 2	Dire	10e. Street and Number	•				Code				-	zen of Wha		•	
	sath v	eral	8709 Bradford Road	1 2. Was Decedent	Ever in U.S	S 13 V		20901		nin? (Spe	cify Yes or No		ted St			
	ter de	Funeral Director	1 X Never Married 2 Married	Armed Forces?	•					, Puerto	cify Yes or No Rican, etc.)		Black, \			
036	al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		-	1 🗌 Yes	2 X No	Specify:				Specify:	Whi	te	
21215-0036	72 hours after death with the Maryland netural; or items 23c or 28a-f ahow deal Exami as must be rodified at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced	kind of wo	rk doné d	luring most	t of worki	ng	16b. Kii	nd of Busin	ess/Ind	lustry	
121	Athin ne.	d H	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT i)			Pos	nking			
2	iled v Hygie ther t nt, th	ပိ	12 17. Father's Name (First, Middle, Last)			Bank	UIII	cer	18. Mothe	r's Name	(First, Middle,					
Maryland	d be f antal } ted of	o Be	Henry Myrton Myers	3							e Bush					
Z	should nd Me mark	ř	19a. Informant's Name/Relationship (Type			19b. Mailir	ng Addres	s (Street a			Il Route Numbe	er, City o	Town, Sta	te, Zip	Code)	
Z	nd 2 alth ai 27 is		Richard M. Fletcher	/ Nephe	ew	424	N. Aı	mist	ead S	St.,	Alexan	dria	, Vir	gin	ia 2231	.2
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or items 23s or 28a-f ahow amy njury or other traumatic avant, the Madical Examinating the routilish at once.		20a. Method of Disposition		20b. PI	lace of Dispo	sition (Na	me of other plac	a)		ate	20c. Lo	cation - Cit	y or To	wn, State	
Ē	Page		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1					y 5/	13/06	River	dale,	, MI	2073	7
alt	arrit. apartr pouts ny nji	1	21. Signature of Funeral Service License	10		22	Name a	nd Addres	s of Facility	y Luary	Servi	ce.]	P.A.			
-	205 2		In a forest	M0095			933 (Sist	Ave.	LL,	Silver	Spr	ing.	VID_		
			23a. Parl 1. Enter the disease, or compli- shock, or heart failure. List only on	cations that cause e cause on each l	d the death ine.	. Do not ent	er the mo	de of dyin	g, such as	cardiac (or respiratory a	rrest,			Approximate Interval Betw Onset and D	ween
	Physician		tmmediate Cause (Final disease or condition resulting in death)	Sepsis										1	Days	
	/Medical Examiner			Due to (or as		uence of):									Torint	
	AN	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Pneumor Due to (or as	11a sa consequ	uence of):								-	Day	
	outed id ansit	Examine	Light historian availty													
ó	death certificate be executed eattending physicien and of for use as the burial-transit		resulting in death) Last	Due to (or as	a consequ	uence of):										
8760,	ate be hysici the bu	Physician/Medical												-		
39 ×	death certifica attending ph	Mec	IF FEMALE:	3c. If yes, outcome	of progna	nov							201 0-1	6 -4 - 15		
Вох	attend for us	ian/	in the past 12 months?	1 Live birth 4 Pregnant a	2 Fetal	death 3[Ectopic p					1	23d. Date o Month			'ear
P.O.	that the de led by the a detached	yslo	1 □ Yes 2 X No 9 □ Unknown	9 Unknown	it titll o or de	5411 5	3 Omer (3)	Decity)								
	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions con	tributing to death t	out not resu	ulting in the u	nderlying	cause giv	en in Part I.		23e. Did t	obacco u	se contribu	te to th	e cause of de	eath?
Records,	quires n sign	ed by	Dehydration								10	Yes 2	□No 3[] Prob	ably 4X☐U	Inknown
00	aw requir s been si 2 should	plet	Dementia								24a. Was		24b. Wer	e auto	psy findings a npletion of ca	available
Re	The law ate has l	Completed									perfo	rmed?	dea	th?	2[XNo	1830 07
Vital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?							of Death	Check only o	one)				
of V	Physician: this certific ral director,	은	1 ☐ Yes 2XX No	ospital: 1 Inpati		ER/Outpatier		- 1	4 11 140		me 5 Resi			Specify	"	
n o	ding P	on:	27 Manner of Death 1 XNatural 5 Pending	28a. Date of Inju (Month, Da	ay Year)	28b. Time o Injury	f M	28c. Injun Worl	yat k? Yes 2⊡!		28d. Describe I	how injur	y occurred			
Division	or Attanding after death. Diractor: Afte in by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of In	iurv - At ho	me, farm, str			103 2 []		28f. Location (Street an	d Number o	or Rura	l Route Numi	ber.
Οį	after Dirac	Certification;	4 ☐ Homicide determined	building, e	tc. (Specify	1)		y , 000			City or To	wn, State)			
	spita nours neral		29a. Certifier 1 X Certifying Phys													
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only 2 Medical Examination)	ner: On the basis of and manner si		tion and/or in	vestigation	n, in my o	pinion, dea	th occurr	ed at the time,					'
		Σ	29b. Signature and title of pertifier				29	c. Licens	e number			29d. Dat	e signed (A	Aonth, i	Jay, Year)	
	3		- white	a				D323	32			May	10,	2006	5	
			30. Name and address of person who co					C+-	#220	0 : 1	***************************************	w d	MT	2004	2	
	Diper Ch	oto	Suresh K. Gupta, 1	32. Regist	rar's Signa	ture			# 220,	511	ver Sp	ring		2090	JZ	
	St Regist	ate rar	MAY 1 1 2	006		K. A	park									

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

		1	State of Maryland / Department	artment of Health and M rtificate of Death		ienė () () 6 og. No.	16739
			Decedent's Name (First, Middle, Last)		2. Date of Deat Month	h Day Year	3. Time of Death
	Physicia	_	Elaine Marion Manford		May	10, 2006	2353 м
	/Medic Examin		la. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	<u>, </u>	4c. County of Dea	th
	Examin	·	Montgomery General Hospital	Olney		Montgome	ry
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		128-18-0992 1□M 2₺F 79 Yrs.		Jan 15,	1927 New	York
7	2 200	-	Usual Residence of Decedent 10b. County 10c. City, Town or Low	ocation			10d. Inside City Limits
3	sho	5					1 ☐ Yes 2 No
4	28a-f	O	Taryland Montgomery Montgomer	ry Village	1-	0g. Citizen of What C	ountry?
4	a or	ᆸ		20886		Inited Sta	-
-	ns 23	Funeral	11 10 1	Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto		14. Race - Am	erican Indian,
	r then	Fun	1 Never Married 2 Married 1 Yes 2 No		Rican, etc.)	Black, Whi	te, etc.
3	urs a	þ	3 ☐ Widowed 4 Mg Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No Specify:		Specify: W	hite
	z no	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ing	16b. Kind of Business	s/Industry
7	e e .	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
7	ygien ygien ygien th	Š	12 Homen	laker 18. Mother's Name	(First Middle 8	Own Home	
	ntal H ntal H od ott	Be	17. Father's Name (First, Middle, Last)	Unavail		marceri Sumame)	
7 5	Mer Marke Marke	ျှ	David Marsh	ing Address (Street and Number or Run		City or Town State	Zin Codel
2	n and h and ris n traun		, , , ,		lney, MI		Zip Code)
֡֡֟֝֝֡֝֟֝֜֝֝֜֝֜֝֝֜֝֝֜֝֝֜֜֝֝֜֝֜֝֜֜֝֝֜֝֜֝֜֝֜	Healt Healt Sm 2					20c. Location - City o	r Town, State
2	of E and		1 Burlai 2 Cremation 3 Hemoval from State		06	Beltsville	MD
parilliore,	permit. Pages 1 and 2 should be filed within 72 hours after beath with the maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Exercitest it ust be notified at once.	. 1		ke Crematory 5-11- 2. Name and Address of Facility			, 110
0	Depar Depar Impor any ir		M00956	2 Name and Address of Facility nibadeau Mortuary 33 Gist Ave., LL S	Service,	P.A.	20910
			23a Part1. Enter the disease, or complications that caused the death. Do not en				Approximate Interval Between
ı.			shock, or heart failure. List only one cause on each line.				Onset and Death
1	'nysicia n /Medical		disease or condition resulting in death) Cardiac Arrest Due to (or as a consequence of);				
	Examiner		Atrial Fibrillation	on			
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury transmitted deports.				
	cuted od ransit	Examiner	triat irritiation everits				
ĵ	e exerian ar		resulting in death) Last — Due to (or as a consequence of):				
9/60	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d Dementia				
و	artifica ing p	Mec	IF FEMALE:				
X R R	leath certifics attending pl	Physiclan/Me	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	Day Year
	res that the de signed by the a be detached f	ysic	1 Yes 2 No 9 Unknown		-		
J.	that the bod by detact	h h	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tol	pacco use contribute	to the cause of death?
as,	uires sign ld be	d b	Irritable Bowel Syndrome		1 🗆 Y	as 2□No 3□F	Probably 4 🖔 Unknown
Vital Records,	w requ	Completed by	Psychosis		24a. Wasa	n 24b. Were a	utopsy findings available
Ž	he lar e has ige 2	mc	1 Sychos 1 S	100	autops perfori	ned? death?	completion of cause of s
		e C	25. Was case referred to medical	26. Place of Deat		21	5 20110
	Physician: r this certifica ral director, p	O B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatie	Othor		ence 6 Other (Sp	ecify)
Division of	g Phy er thi	n:T	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at Work?	28d. Describe h	ow injury occurred	
0	vttendin death. ctor: Aft y the fur	atlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
<u>≥</u>	r Atte er de recto	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (S. City or Town	treet and Number or F n, State)	Ru <i>ral R</i> ou <i>te Number</i> ,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer						
	Hosp 4 hou Funei ely fill	ical	29a. Certifier (Check only (C	ith occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the c red at the time, d	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
	the I	Medical	one) and manner stated. 29b. Signature and title of certifier	29c, License number		9d. Date signed (Mor	
	Twit To To To To To To To To To To To To To	_	A Paris S	D56691		May 10, 20	
	2		- music kent cent			,,,	
			30. Name and address of person who completed cause of death (Item 23a) (Type	Park Circle, Silve	r Spring	. MD 2090)6
	St	ate	Ghousia Sultana, MD 12107 Heritage I 31. Date filed (Month, Day, Year) 32 Registrar's Signature	WA OTTOTOS DITLYE	PALTITE	, 2070	<u> </u>
	Regist		31. Date filed (Month, Day, Year) MAY 1 1 2006 32 Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 9:08 AM Lillian Mae Martin 2006 Mau 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegani Memoria 10c If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/29/1924 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🛱 F 152-12-1029 Yrs. 82 Maryland Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f ehow amy njury or other traumatic event, if a Medical Examinar must be notified at once. 1 ZYes 2 No Completed by Funeral Director Cumberland **Allegany** 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21502 USA 10 N. Liberty Street, Apt #313 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: f Yes, Give rear or Dates: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home 11 Dietician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be See Tresa Jesse Lowery ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa A. Mason / daughter 606 Shriver Avenue, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Vet. Cem @ Rocky Gap 05/19/2006 Flintstone, MD 21. Signature of F neral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. Ciclama 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 5 DAYS RESPIRATORY FAILURE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the sequence of injury that initiated events resulting in death) Last b. EMPHYSEMA 10 YEARS Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 Yes 2 🗌 No 3 ☐ Probably 4 ☐Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 1 No certificete 1 Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 🗀 Yes 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28b. Time of Injury Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation s efter death.
If Director: Af
id in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled Hospitai 24 hours e Medical 29a, Certifier Fig. 6. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. WILLIAM LAMM, 21502 900 SETON DRIVE, CUMBERLAND, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 17 2006

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Martha L. Beckett Morris 2006 10:00 PM Mai 8, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY REHAB & NURSING CENTER SALISBURY, MD. 2 21804 WICOMICO 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours Min. 1 □ M 2 🔀 F Director 216-70-2192 PA Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 le marked other than "natural", or Items 23a or 28e-f ehov traumatic event, ins Madical Examinar must be notified at 1X Yes 2 □ No Completed by Funeral Director MD Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1006 Fairground Drive, Apt. 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Yes 2 No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+) Salesperson Retail 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emory Beckett Violet L. Beckett ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 Violet L. Thomas/mother 1006 Fairgound Dr., Apt. 7, Salisbury, MD 21801 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State parmit. Pages Department of I Important: if Its any injury or o 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Union UMC Cemetery 5/13/2006 Delmar, MD 21. Signature of Femeral Service Licenses 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mala /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. After this certificate has been signed by the funaral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 4 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 TNo 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 Yes 2 146 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Maturat /s after dea. 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours a 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ylately 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAY 12

- a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

29d. Date signed (Month, Day, Year)

Type or Print in Black Indelible Ink

Please Type or Print in Black Indelible ink
State of Maryland / Department of Health and Mental Hygiene
0 15 1 5 5 11

Robert McMannis	1.	State of Maryland / Department of Health and Mental P	rygierie	000	1/2 71
		For State equistrar Amend #5 Per FH G856 6/09976Fcate of Death	2. Date of Dea	leg. No.	3. Time of Death
Physician Medical Examine		Robert Lee McMannis	Month May 21, 2		0938 hrs
		ta. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat		4c. County of Dea	th
		34 1/2 Virginia Avenue Cumberland		Allegany	
Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Mi		rth (MM/DD/YYYY) 9. E	ian
Director		219-54-12/3 219-12-5457 1⊠ M 2 F 56 Yrs. Months Days Hours Mil	n July	9, 1949	country) MD
	_	Usual Residence of Decedent	•		10d Inside City Limits
w any		10a. State 10b. County 10c. City, Town or Location			1 Yes 2 No
-f sho		MD Allegany Cumberland 10e Street and Number 10f Zip Code	1.	10g. Citizen of What Co	25.
Mary rr 28a ied at	Director			USA	unity:
15-0036 High within 72 hours after death with the Maryland I Hygiene I Hygiene do do ther than "matural", or items 23a or 28a-f she of other than "matural", or items 100 or 100	<u> </u>	34 Virginia Avenue 21502 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (5	Specify Yes or No		erican Indian, Black,
items is ust be	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puert		White, etc.	,
fter de		3 Widowed 4 Divorced If Yes 2 No specify:		Specify: W	hite
atura atura	a D	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b. Kind of Busines	s/Industry
Gallin 12 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	, , , , , , , , , , , , , , , , , , ,	- /-	
003 within yiene ver th	ĔL	12 n/a 17. Father's Name (First, Middle, Last) 18.Mother's Nam	ne (First Middle	n / a	
filed at Hyge ed off	Be C	The family of the first of the		McMannis	
D 24215-0036 should be filed within 7 and Mantal Hygiens it is marked other than ratic event, the Medica		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	r Rural Route Nu	mber, City or Town, Sta	
MD 2 sho alth and m 27 is aumati		Anna Mongold/daughter 14301 Cresap Mill Rd	l; Oldto	wn, MD 2155	5
Ce, Pand Healt Healt Citem		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	or Town, State
Pages em of ent: M	- 1		/25/2006	LaVale,	MD
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mennal Hygiene happenent: If item 27 is marked other than "matural", or items 23a or 28a-f show injery or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility S	carpelli	Funeral H	ome, P.A.
ක දුරිපිම		108 Virginia Ave.			
Physician (Medical	1	art I. Enter the diseas I or Implications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cluse on each line.	or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a Smoke Inhalation and Thermal Injuries Due to (or as a consequence of):			Death
		h			
	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
	Examiner	Colsease or injury that initiated events resulting in death). Last use to (or as a consequence of):			1
		d			
8 5 = 1	Medical	UNPENDED AMENDED			
760, cate be exphysician the burial		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of deliv	· ·
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BOX or death or the attented for us	ysic	1 Yes 2 No 9 Unknown 9 Unknown			
- E 55		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute	
ords, P.O. w. requires that is been signed is should be detailed.	d by		1 🗸 Y	es 2 No 3 P	obably 4 Unknown
rrds requi	leted		24a. Wa:	ppsy prior t	autopsy findings available : completion of cause of
Reco	ompl			ormad? death 2 No 1 ✓	
tal Recian: The centificate		25. Was case referred to medical 26. Place of Death (Chec	ck only one)		
Vital F hysician: this cetufa	e e	1 V Yes 2 No		Residence 6 🗸 Ott	ner: Scene
n of ling Ph After t	T:U	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Panding PolyNo. FOUND: 1 Yes 2 No.		how injury occurred gulfed in fire	
Sior trend death ctor: y the	atic	2 Accident Investigation May 21, 2006 0933 hrs	1005 1005	(Ot1 1 N 1	Dural Davida Musebas City
Division of Vital Records, nator Attending Physician: The law require is after death. al Director: After this centificate has been sided in by the funeral director, page 2, should he	Certification:	3 Suicide 6 Could not be determined (Specify) Single Family	or Town,		Rural Route Number, City
file non	S	4 Homicide (Specify) Single Family 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	<u>`</u>	· · · · · · · · · · · · · · · · · · ·	
Division of Vital Frontier to the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this cent completely filled in by the funeral director.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d at the time, dat	e and place, and due to	the cause(s)
Vorti	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (1	Month, Day, Year)
		Quet MD O.C.M.E.		May 22, 2006	
4	İ	30. Name and address of person who completed cause of death (Item 23a)		•	
0		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201		
	ate	31. Date filed (Month, Day, Year) MAY 2 5 2006 Registrar's Signature			
P Regist	rar	MIAI O CUUO			

			1. For State	State of Marylar				Mental Hygi	_	16716
			Registrar		Cei	rtificate of	Death	Re	g. No UUb	16/43
П	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Media		Mark Cloyd McCra 4a. Facility Name (If not institution, give si			4h City Town	or Location of Dea		18, 2006 4c. County of Death	11:55 P M
	Examir	ier	Williamsport Nursi			William			Washingto	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.			If Under 24 Hrs	8. Date of Birth	0.0:45	place (State or Foreign
	Director		Usual Residence of Decedent	M 2□F	90 Yrs.			February 1	9,1916	PA
	/land		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	e-fel	ctor	MD Washingto	on Har	ncock					1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	eeth v	eral	13 Funk Avenue	2. Was Decedent Ever in L	18 121	21750		Specify Ves es No	USA 14. Race - Ameri	one Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinar must be notified at ance.	by Funeral	1 ☐ Never Married 2 [X] Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		If Yes, specify Cub		Specify Yes or No- to Rican, etc.)	Black, White	, etc.
21215-0036	2 hou	Completed by	15. Decedent's Educ	ation	16a. Deced	dent's Usual Occu	pation		6b. Kind of Business/Ir	
21	ithin 7	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	1		pation during most of wo ad)	1		
12	iled w Hygier ther th		12 17. Father's Name (First, Middle, Last)		Owner	/Operato		Re me (First, Middle, M	etail Elect	rical
auc	d be delle l	To Be	Edward McCray					ie Truax	aloen Sumame)	
ary	shou and M mari	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Stree			City or Town, State, Zi	o Code)
Σ,	and 2 selth an 27 in 27 is		Marian E. McCray/W				e Hancoc	k, MD 2175	50	
Baltimore, Maryland	it of H		20a. Method of Disposition 1 DBurial 2 □ Cremation 3 □ Re		Place of Dispo cemetery, cren	sition (Name of matory or other pla	1		Oc. Location - City or T	own, State
臣	iit. Pa artmer ortant: Injury		4 □Donation 5 □Other (Specify) 21 Signature of Funeral Service License			n Memori			gerstown,	
Ba	Depermination of the party is any in party in pa		1	HILL	1 - 335		W. NES		st Main Str cock,MD 217	
			23a. Part1. Enter the disease, or omplice shock, or heart failure. List only on	cations that caused the deal						Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	Renal	Fail					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	uence of):			. >		TW ECK
	4	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	clero	nc Ken	o vasc	ular Dis	ease	years
	outed and a	Examiner	Cause (Disease or injury that initiated events							
760,	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a consec	juence of):					
	physic physic s the b	dicai	d.		W-W-		-			
	death certifica e attending ph id for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna	ancy				23d. Date of deliving	904
P.O. Box	thet the death certifica ed by the attending ph detached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown]Ectopic pregnanc] Other <i>(specify)</i> _	:y		Month	Day Year
	The law requires thet the site has been signed by the sage 2 should be detache	Phy	9 ☐ Unknown Part II. Other significant conditions cont	tributing to death but not res	sulting in the ur	nderlying cause or	ven in Part I	23e Did toba	cco use contribute to t	he cause of death?
Records,	juires the signed I	d by	^ \	sease	anning an inio di	noonly and cause gr	voir art arti.	1 ☐ Yes		pably 4 Unknown
Ö	aw requir s been si 2 should	Completed	Congestive Hea	At Failus	-			24a. Was an	24b. Were auto	posy findings available
		E	Dementia					autopsy performe	prior to co death? 1 Yes	opsy findings available impletion of cause of
/ita	ysician: The l is certificate ha director, page	Be (25. Was case referred to medical examiner?					ath Check only one		•
o	Physic ruthis cral dir	- T	1 Yes 2 No	ospital: 1 Inpatient 2 Inpatient 2 Inpatient 2	ER/Outpatien	J DOA			ce 6 □Other (Specil	(v)
on	Attending Physician: r death. ector: After this certific. by the funeral director.	ation	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo	rk?]Yes 2 □ No	28d. Describe how	r injury occurred	
Division of Vital	7 2 2 2	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	Hospita 4 hours Funerel ely fillec	Medical C	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death	n occurred at the ti vestigation, in my	ime, date and place opinion, death occ	a, and due to the cau urred at the time, dat	se(s) and manner as s e and place, and due to	tated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	se number	290	d. Date signed (Month,	Day, Year)
			Cynthia Kutt	nei-Sand	lo mo	D4	7451		ay 19, 20	
	2		30. Name and address of person who con				ursing H	154	North A	rtizon-Stre
			Cynthia Kuther-So	32. Registrar's Signa	HIAMS	boy N	ursing P	one, w.	Mams port	Maryland 1795
	Sta Registr		31. Date filed March, 20, 502006	January Signa	Social	20			6	1795

DHMH 17 Rev 1/2001

Mc Cray 118,3006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 9, MCGOVERN MAY 10:30A M WILLIAM MICHAEL 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 57 216-60-4193 Director Yrs May 3,1949 Massachusetts Usuaf Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at Maryland Frederick **Braddock Heights** 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6012 Jefferson Blvd. 21714 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No fl Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'na eny injury or other traumatic event, the Mading once. Elementary/Secondary (0-12) Colfege (1-4or 5+) Custodial Work Beverage Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Suman William. Robert McGovern Adelaide Duti1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adelaide McGovern/Mother 5955 Quinn Orchard Rd Box 149 Frederick, MD 21704 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/14/2006 Arlington Nat. Cem 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part That the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hapiration Plue to (br as a consequence of) Monmunic Leeu une /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical 23c. ff yes, outcome of pregnancy 1☐Live birth 2☐Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \) 26. Place of Death Check only one Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X npatient ဥ 2 ER/Outpatient 3□ DOA this After this 27. Magner of Death 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. J. Fleming 610 9th Avenue Brunswick, MD 31. Date filed (Month, Day, Year) State Registrar 2 2006

State of Maryland / Department of Health and Mental Hygiene? [] [] [For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** HENRIETTA 8, A M MAY 2006 10:45 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 7407 TARFSIDE LANE GAITHERSBURG MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 ☐ XF Yrs. Director 213-29-2220 68 11/1/1937 SIERRA LEONE Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or Items 23s or 28s-f show The Medical Examiner must be notified at 1 ☐ Yes 2 No MARYLAND MONTGOMERY GAITHERSBURG Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7407 TARFSIDE LANE 20879 SIERRA LEONE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ BLACK 3 N Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) PRINCIPAL EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ISAAC COLE HENRIETTA LISK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RODNEY NICOL - SON 12530 POST CREEK PLACE; GERMANTOWN MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) GATE OF HEAVEN CEMETERY 5/20/2006 SILVER SPRING, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME Myelin . K 11800 NEW HAMPSHIRE AVENUE; SILVER SPRING MD 20904 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** uears orondry ar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of): Physiclan/Medical detached for use as the attending IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cate has been sign, page 2 should be 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed 2 No 2 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 5 Residence 6 Other (Specify) 3 DOA To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 Yes 2 No 2 T Accident investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10ms 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) ille Pik 'd l Tricia

State Registrar

31. Date filed (Month, Day, Year) MAY 12

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

3 Registrar's Signature

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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	1- For State Certification Cer	icate of Death	Reg. No.	JUD 10/4				
Physician/	Decedent's Name (First, Middle,Last)	Date of Death Month Day Year	3. Time of Death					
ledical Examiner	Corey I. Oliver 4a. Facility Name (if not institution, give street and number)	Ab City Town or Location of Dooth	May 20, 2006	2243 hrs				
	St. Agnes Hospital	4b. City, Town, or Location of Death Baltimore	4c. County o	imore				
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24Hrs	s. 8. Date of Birth(MM/DD/YYYY)	Birthplace (State or				
Director	218-21-8085 X M 2 F 22	Months Days Hours Min	Sept 23,198 Sept MD					
	Usual Residence of Decedent							
w any	ND D-1+1	wn or Location Saltimore		10d. Inside City Limits				
faryland 28a-f show Lat once			-	1 X Yes 2 No				
the Maryland a or 28a-f sh tified at once Director	10e. Street and Number	10f. Zip Code	10g. Citizen of Wh	at Country?				
ith the 123a c	3387 St. Benedict Street 11. Marital Status 12. Was Decedent Ever in U.S.	21229 13. Was Decedent of Hispanic Origin? (Sp	USA	- American Indian, Black,				
or items 23	1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto						
safter d	3 Widowed 4 Divorced If Yes 2 X No	1 Yes 2 No specify:	Specify.W	hite				
72 hours at Exami		Sa. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use retired.)		siness/Industry				
36 in 72 hau " lical E	Elementary/Secondary (0-12) College (1-4 or 5+)	Stock Clerk						
-0036 d within 'giene ther than ther than	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)	market				
215-0036 be filed within 7 and Hygiene ched other thau ent, the Medica Be Comple	David A. Oliver, Sr.		L. Mayo					
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene is marked other than "natural", or items 23a or 28a-f she atic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		19b. Mailing Address (Street and Number or I						
Mark Car	Linda L. Mayo - mother 20a. Method of Disposition 120b. Place	3516 Baltimore P						
Ealtimore, ocmit Pages an Department of Healinportant: If iten nighty or other transmingury or other transming	1 V Burial 2 Cremation 3 Removal from State crem	ce of Disposition (Name of cemetery, matory or other place)		City or Town, State				
- d a E 5	4 Donation 5 Other Specify: St.	Mary's Cemetery 5	/24/06 Silve	r Run, MD				
Esalti permit Departiti Import	21. Signeture of Funeral Service Licensee	22. Name and Address of Facility Little's F.H.	3/ Maple Ave	PA 17340				
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do							
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Methadone intoxica	tion		Between Onset and Death				
Zzartimer	or condition resulting in death) Due to (or as a consequence of):							
	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):							
mine	cause. Enter Underlying Cause							
ed	events resulting in death) Last Due to (or as a consequence of):							
7 70 8	1 0	a,PII,27,28a-f,perME,g856,6	5/16/06 TT					
freate be executing physician and the burial - tra	IF FEMALE: 23c. If yes, outcome of pregnan		23d. Date of	delivery				
687 certifica ding p	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregna		Day Year				
Sic large at Sic	4 Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)						
<u> </u>	Part II. Other significant conditions contributing to death but not resu	Iting in the underlying cause given in Part I.	23e. Did tobacco use contrit	oute to the cause of death?				
∂	Chronic alcoholism		1 Yes 2 No 3	Probably 4 🗸 Unknown				
Records, The lay require freate has been sig. page 2 should be				/ere autopsy findings available				
Reco		···	performed? d	rior to completion of cause of eath? Yes 2 No				
Division of Vital Records, that is required and or Attending Physician: The lay requires for death at Director. After this certificate has been shed in by the funeral arcetor, page 2, hould britification: To Be Complete artification: To Be Complete		26.Place of Death (Check		V les 2 No				
Vital hysician: I orrector	1 Yes 2 No Inpatient 2 EF	R/Outpatient 3 DOA Other Nursin	ng Home 5 Residence 6	Other:				
1 Of 1 of 1 ling Ph		3b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurre	ed				
Sior Mrcnd death death ctor: yy the	Pending Fnd 5/20/2006 F:	nd 8:00 am 1 Yes 2 X No	unk					
Division of Attending on Strending on Attending on Strending on Strending on the Bull of the Strending of th	3 Suicide 6 A Could not be determined (Specify) Found at	e, farm, street, factory, office building, etc. residence	28f. Location (Street and Number or Town, State) 3387 Sa Baltimore, MD	or Rural Route Number, City Sint Benedict St				
호를 함트 8	20a Cartifier							
The state of the s								
2	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signe	ed (Month, Day, Year)				
	high his mis	O.C.M.E.	May 21, 20	06				
	30 Name and address of person who completed cause of death (Item 23	da)						
		enn Street, Baltimore, MD 21201						
State Registra	NINY 2 6 21910 1 12s. Ka	Coasts)						
DHMH 7 Rev 1/2001		ORIGINAL						

State

31. Date filed (Month, Day, Year) MAY 2 5 2006 Registrar

30. Name and ag

29b. Signature and title of conflier

Poirier

M.D. 186 Thomas Johnson Dr. #105 Frederick, MD 21702 39. Registrar's Signature

W ress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 09518

29d. Date signed (Month, Dey, Year) May 23, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY If Under 1 Year KVILLE If Under 24 Hrs. HOVENTIST SHADY GROVE 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Year Months 1 ☐ M 2 💢 F NONE Yrs. 05 10 2006 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23e or 28e-f ehow eny injury or other traumetic event, the Medical Executar Institut be notified at 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State 1 Yes 2 □ No MARYLAND HERSBURG MONTGOMER Be Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 085 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify BLACK 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) OWUSU 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) AITHERSBURG 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State CYCL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SHADY GROUE ADVENTIST 23a. Part1. Enter the disease, or complications that careed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KEMATUR Physician /Medical Du to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (clease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner and I-transit Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No
9 Unknown 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No this certificate 1 Yes 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 XNo 1 Inpatient 3□ DOA ို 1 🗌 Yes 2 ER/Outpatient 27. Manner of Death 1 Natural 2 Accident 28d. Describe how injury occurred 28b. Time of Certification: After 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one)

State

MAY 2 Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature 5 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ENTER DRIVE,

29c. License number

29d. Date signed (Month, Day, Year)

Amended #s 23a(a), 23a(b) Allega

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	y Co.	0.	1 - State Registrar	State of M			artment of F rtificate of		Mental H	ygien Reg. N	ZUUb	16749		
	Physici	20	Decedent's Name (First, Midd	lle, Last)	2					eath Da	ay Year	3. Time of Death		
	/Medi		Virginia		Poturica				2006	20:04 M				
	Examir	ier	4a. Facility Name (If not institution)	4b. City, Town, o	lb. City, Town, or Location of Death			4c. County of Death				
			MEMORIAL HOSPI 5. Social Security Number		ge (In yrs. last biri	thday)	CUMBERL. If Under 1 Year	AND If Under 24 Hrs	S. 8 Date of B		LLEGANY	rthplace (State or Foreign		
Н	Funeral Director		217-28-7759	1□M 2∏F	-	Yrs.	Months Days	Hours Min	8. Date of B (Month, D	193	2 Ma	aryland		
	pu *		Usual Residence of Decedent 10a. State 10b. Count	,	10c. City, Towr	orlo	ecation					10d. Inside City Limits		
	Aaryla I ehov	ō		Allegany	Toc. Oily, Town	r or Lo	Cumber	land				1 Yes 2 No		
	the 28a-	Director	10e. Street and Number			_	10f. Zip Code			10g. C	itizen of What C	ountry?		
	h with		11700 W	illow Creek	Lane. NE			21502			USA			
	ter deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S	Specify Yes or N	0-	14. Race - Am Black, Whi			
Maryland 21215-0036	vithin 72 hours after death with the Maryland liene. r than "naturel", or Iteme 23a or 28a-1 ehow the Medical Examiner must be motified at	b	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 Yes 2 7			1□Yes 2∏No	Specify:	,,		Specify:	White		
2	72 h	etec		nt's Education est grade completed)	16a.	(Give	dent's Usual Occup	during most of wo	orking	16b. l	Kind of Business	/Industry		
<u>2</u>	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	irte. I	DO NOT use retired							
0 0	Hyge III		17. Father's Name (First, Middle	. Last)			Homemak		me (First, Middl	e, Maide	Home n Sumame)			
a	D 2 3 0	To Be	Edward	Rov]	Frame	Ethe	1	Εd	na	Miller		
ary	2 shoul and Me le mark sumati	_	19a. Informant's Name/Relation	ship (Type, Print)	19b.	Mailir	ng Address (Street	and Number or R	ural Route Num	ber, City	or Town, State,	Zip Code)		
<u>``</u>	12 th		Joseph M. Potu	rica / son								d, MD 21502		
Baltimore,		13	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from State	20b. Place of cemeter	Dispo y, crer	sition (Name of natory or other place	ce)	Date	20c. L	ocation - City or	Town, State		
₽	t. Partmen		4 Donation 8 Other (MD Vet	. (Cem @ Roc	ky Gap (05/08/20	06	Flintst	one, MD		
Ba	permit. Page Department o Important: If eny Injury or once.		21. Signature Fune al Service	Licensee								Home, P.A.		
		6	23a. Part1. Enter the disease, of	r complications that cause	d the death. Do n		04 Decatu er the mode of dyin				id, MD	21502 Approximate		
Physician /Medica	Physician		Interval Betwoen the Renal Failure Immediate Cause (Final Renal Failure Onset and E											
	/Medical		disease or condition resulting in death)		AILURE 1		TO ARTE	LOSCLER	DSTS			2 WEEKS		
Examiner			Arteriosclerosis								2 WEEKS			
	D 118	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
	icate be executed physician end s the burial-transit	Examiner	cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
68760,	be ey	alE		500 10 (0) 23	a consequence (,,,								
687		edical		d										
Вох	eath certific ettending pi for use es f	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			-				23d. Date of de	livery		
	law requires that the death certifes been signed by the ettending 2 should be detached for use e	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a	2 ☐ Fetal death It time of death		Ectopic pregnancy Other (specify)				Month	Day Year		
0.	that the de ed by the detached	Phy	9 Unknown			41	4.4.		00 - 0:4					
	ires tha signed I be de	þ	Part II. Other significant contributing to death but not resulting in the underlying cause given in Part I.											
Š	w requir been si should	Completed	BELDED								-			
Vital Records,	o £ 0	ם							24a. Wa auto peri	san opsy ormed2∕	24b. Were a prior to death?	utopsy findings available completion of cause of		
ā	tician: Th certificate rector, pag	ပိ	25. Was case referred to medical	al V				OS Place of Do	1 ☐ Yes ath (Check only	2 1 No	1 ☐ Yes	2 □ No		
<u>=</u>	ysician: is certific director.	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospitaf:	ent 2 ER/Out	tpatien	t 3 DOA Oth	00	dome 5 Res		6 ∏Other (Spe	icity)		
o L	Attending Physician: r death. sctor: After this certific by the funeral director.		27. Manner of Death 1 ☑Natural 5 ☐ Pend	28a. Date of Inju (Month, Da		ime of	28c. Injun Wor		28d. Describe					
S	ttendir death. tor: Af the fu	catic	2 Accident invest	igation	,			Yes 2 □No						
Division		Certification:	3 Suicide 6 Could 4 Homicide deten	nined 286. Place of In	jury - At home, fai tc. <i>(Specify)</i>	rm, str	eet, factory, office		28f. Location City or To			ural Route Number,		
	poltal corrs e ierel (29a. Certifier 1 V Certify	ng Physician: To the best	of my knowledge	doath	a coourned at the time	no, data and place	and due to the		\			
	To the Hospital or within 24 hours effe To the Funerel Dir completely filled in	Medical	(Check only 2 Medica	Examiner: On the basis of and manner st	of examination and	/or inv	restigation, in my o	pinion, death occi	urred at the time	, date an	d place, and due	o stated, o to the cause(s)		
	To th within To th	Me	29b. Signature and title of certific				29c. Licens	e number		29d. Da	ite signed (Moni	h, Day, Year)		
4	NKS) c/ ry/					D36766		м	AY 4, 20	206		
	SDB		30. Name and address of persor	who completed cause of	death (Item 23a) (Туре,	Print)	200,00		FL	اک و ۱۲ مدد،			
	2		POONAI, VIKRAM			TON	DRIVE, (CUMBERLA	ND, MD 2	1502	2			
	Sta Registi		31. Date filed (Month, Day, Year	200	rar's Signature		M. s							
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Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State o	of Maryla		artment o	f Health and I of Death		giene	06	16750		
	Dhuciei	20	Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year 3. Time				
	Physici /Medic		CHARLIE WALKER POULSON, SR. 05								06	6236 M		
	Examir	er	4a. Facility Name (If not institution			14.6.	4b. City, Town	n, or Location of Death	h		ty of Death	•		
			5. Social Security Number	VAV MOA 6. Sex		rs. last birthday	If Under 1 Ye		8. Date of Birt			place (State or Foreign		
	Funeral Director		225-48-3697	1 M 2 □ F		72 Yrs.	Months Da		8. Date of Bird (Month, Da Sept. 15	y, Year) 1933	Virgi	ntry)		
			Usual Residence of Decedent	1					popt. 10	, 1000	1			
1	irylan ihow	_	10a, State 10b. County			City, Town or L	ocation				1	0d. Inside City Limits		
369	the Marylan 28e-f show notified at	cto	Maryland Wicor	n100	56	alisbury						1 ☐ Yes 2 🖾 No		
4	vith th	Funeral Director	10e, Street and Number				10f. Zip Cod			10g. Citizen of		ntry?		
£	s 23e	grai	29106 Naylor Mi		edent Ever in	110 12	2180		pacify Vac or No	USA	ice - Americ	ean Indian		
223-	ter de	Ë	11, Marital Status 1 □ Never Married 2 → Mar	Armed Fo	orces?	10.3.		of Hispanic Origin? (S Cuban, Mexican, Puert	o Rican, etc.)	BI	ack, White,			
2	Urs af	ğ							Specify: Black					
	1215-0036 within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28e-1 show the Madical Examiner must be notified at	Completed		nt's Education est grade completed)		16a Dece	dent's Usual Oc	cupation	rkina	16b. Kind of				
3	Marie 17	npie	Elementary/Secondary (0-12)	College (ne during most of wor tired)	Perdue	, Inc.				
Charles	Ped v		10th 17. Father's Name (First, Middle,	(ant)		labor	er	19 Mather's North	ne (First, Middle,	Maidan Suma				
0	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28e4 show eny injury or other treumatic event, the Madical Examinar must be notified at once.	To Be	Jesse	Last/	Pot	ulson, Si	•	Margare	Maideri Stilla	Taylor				
Poulson	Mary nd 2 shot lith and N 27 is mary		19a. Informant's Name/Relationship (Type, Print) Annie V. Poulson/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 29106 Naylor Mill Road - Salisbury, MD 2											
Lio	Item		20a. Method of Disposition			D. Place of Dispersion	osition (Name of matory or other	place)	Date	20c. Location - City or Town, State				
\$	Page Page nent c		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5		Sp						bron, Maryland			
	Balt permit. Departe Import eny inj		21. Signature of Funeral Service	Ligansee Column	len			Idress of Facility 12			- Sal	isbury, MD 21801		
	Physician Medical Examiner private period of the private fund the private fundation and the priv	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to	(or as a cons	Jequance of):	fri Car	Lionzap	N-y			Onset and Death		
	Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed effer death. Director: After this certificate has been signed by the attending physicien and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown								23d. Date of delivery Month Day Year			
	ds, Puires that signed by d be detailed	Š									co use contribute to the cause of death? 2 No 3 Probably 4 ØUnknown			
	sw requires s been sign s should be	ojete	Aur and	Chroni	Pu.	Foiler			24a. Was		. Were auto	psy findings available		
Aut and Charital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 1							perfo	autopsy prior to completion of cause of death?						
	Vital Fision: The certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:	_	Ceno		O.I.	ath (Check only o			-720		
	Phys r this aral di	5	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time of	III 3 DOA	4 Nursing F njury at Nork?	lome 5 Resid			<u>v)</u>		
	nding Inth.	atlor	1 Natural 5 Pendi	ng (Mor igation	ith, Day Year,) Injury		Work? I∏Yes 2∏No						
	Division of the Hospitel or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Sulcide 6 ☐ Could 4 ☐ Homicide detern	nined 288. Place	e of Injury - A ling, etc. (Spe		reet, factory, offi	се	28f. Location (5 City or Tox		ber or Rura	l Route Number,		
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	To th within To th comp	Me	29b. Signature and title of certific	er .			29c. Lic	ense number		29d. Date sign		* '		
	NA		1 (pa	Un				JANAP	3	>	٠٩. ٧	Mal		
	192			who completed cau	se of death (I	tem 23a) (Type	Print) MIU	ed4 and	r 5	MV>6	רתץ	m usu		
	Sta Registi		31. Date filed (Month, Day, Year MAY 1	1 2006	gistrar's Sig	gnature	Coall .							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State	of Maryla		artmen rtificate			nd Me		giene Reg. No	L 0	06	16	751	
1.		- 点	Decedent's Name (First, Middle, Last) 2. Date of Death								ath		3. Time of Dea				
	Physic /Medi		O - +1 ' T TO 1 + 2								Month May	Da Q 2	*	Year	2.1	5 P ^M	
	Exami		4a. Facility Name (If not institution		umber)		4b. City,	Town, or Le	ocation of t	Death	nay .	-	2006 3:15 P ^M 4c. County of Death				
			Montgomery Ge	eneral Hos	spital		0	lnev					Mont	gomei	-17		
	Funeral	2.4	5. Social Security Number	6. Sex		s. last birthday)	If Under	1 Year			Date of Bir	th		9. Birthp	ace (State	or Foreign	
	Director		105-22-0687	1 ☐ M 2 X) F	8.5	5 Yrs.	Months	Days	Hours	Min.	(Month, Da			Coun	_{try)} 7 York		
	pu ,		Usuel Residence of Decedent												TOLK		
	aryla ahow	h.,	10a. State 10b. Count	У	10c. C	City, Town or Lo	ocation							10	Od. Inside C	•	
	8e-1	cto	Maryland Pri	ince Georg	ges]	Cemple	Hills								1 🗌 Yes	2 X No	
	ith th	Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of W	hat Coun	try?		
	23a	B	3320 Huntley				20	748				1	USA				
	tama	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in Forces?	U.S. 13.	Was Deced	lent of Hisp	anic Origin Mexican, F	n? (Specify Puerto Ric	y Yes or No an, etc.)	-		- America			
36	or if	by Fu	1 Never Married 2 Ma	If Yes G	2 ∑XNo live		1 Yes 2		Specify:				Specify:		olc.		
8	ural	d b	3 ☐ Widowed 4 Microse		Dates:									B1	ack		
21215-0036	within 72 hours after death with the Maryland one. than "natural", or items 23e or 28e-1 ahow the Medical Exercitar must be ricitlished at	Completed	15. Decede (Specify only highe	nt's Education est grade completed)	Give kind of work done during most of working							b. Kind of Business/Industry				
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7	lled had her her her h		17. Father's Name (First, Middle	(act)	1	Ac	counta						Museums				
an C	be f	Be		, Last)				18	s. Mother's	s Name (F.	irst, Middle,	Maiden	Sumame)			
3	i Mei Marke	2	Ruben Bender	10							nobtai						
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or itams 23a or 28e-f ahow any injuryogogher traumatic event, the Medical Examplant for notified at once.		19a. Informant's Name/Relation.								oute Numbe				Code)		
o î	l and tealth m 2		Vernon G. Wil	lliams/Son		805	Bonifa	ant Ro	d, Si		Sprin						
0	8 0 E 3		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 Removal from		Place of Dispo cemetery, crer			į	Date	'	20c. Lo	cation - C	City or Tov	vn, State		
Baltimore,	Fant:		4 ☐ Donation 5 ☐ Other (G	Sate of				lay 16	5, 200)6	Silv	er S	pring	, MD	
Sal	eper eper npor ny in		21. Signature of Funeral Service	kicensee	. 00	22	2. Name and	d Address o	of Facility	Hines	s-Rina	ldi	Fune	ral	Home		
_	00 = 0		, and	- On		1.	1800 1	New Ha	ampsh	ire A	Ave, S	ilve	er Sp	ring	, MD	20904	
			23a. Part1. Enter the disease shock, or heart failure. Lis	r complications that	caused the dea	ath. Do not ent	er the mode	of dying, s	such as car	irdiac or re	spiratory ar	rest,			Approximat Interval Bet	6 W860	
	Physician		Immediate Cause (Final disease or condition	~	Dalm	Limie	Cr	oftile	<						Onset and [
	/Medical		resulting in death)	Due to	(or as a conse	quence of):			_								
п	Examiner		Sequentially list conditions	b. ———													
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		(or as a conse	quence of):											
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8760,	ute bu	dlcal		d													
6		Jed	IF FENALE														
Вох	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	itcome of pregn		3=:-					2	3d. Date	of deliver	v		
	0 0 0	101	in the past 12 months?	4□Preg	nant at time of		Ectopic pre Other (spe						Mont	h E	Day Y	'ear	
P.0	that the de led by the a detached t	hys	9 🗆 Unknown	9□ Unkr	iown												
	requires that the reen signed by th hould be detache	by P	Part II. Other significant conditi	ons contributing to o	death but not re	sulting in the ur	nderlying ca	use given is	n Part I.		23e. Did to	bacco u	se contrib	ute to the	cause of d	eath?	
ğ	quire in sig uld b										1 🗆 Y	es 2	No 3	☐ Proba	bly 4 □U	Inknown	
Vital Records,	> 110	Completed									24a. Was a	20	245 146	250 2140-0	sy findings a		
Re	0 0	m C								-	autop:	sy	pri		ptetion of ca		
ā	ilcian: Th certificate rector, pag	ပိ	25. Was case referred to medica	1							1□ Yes	2000		Yes -2	Q No		
5		o B	examiner?	Hospital, 5				Othor			eck only or						
		⊢ ∤	27. Manner of Death	28a. Date		ER/Outpatien 28b. Time of		c. Injury at	4 Nursir		5 Resid						
on	iding Phi th. After thi funeral	ţ	Natural 5 ☐ Pendir	ng (Mor	ith, Day Year)	Injury	M	Work?	2 🗆 No		28d. Describe how injury occurred						
S	Attending r death. actor: After by the fune	Ca	3 ☐ Suicide 6 ☐ Could	not be	of Injury - At h	omo form etc			2 1110		1 (0						
Division	efter Dira	Certification:	4 Homicide determ	build	ing, etc. (Speci	fy)	et, lactory,	OHICE		201.	Location (S. City or Town	n, State)	Number	or Hurai I	Houte Numb	oer,	
	pita ours ierei filled		29a. Certifier Certifyin	ng Physician: To the	a boot of my ke												
	Hos 24 h Fun Fun	edical	(Check only 2 Medical one)	ng Physician: To the bearings: On the b	asis of examination and states of examination and stated.	ation and/or inv	estigation, i	t the time, o in my opinio	date and pi on, death o	occurred a	due to the c t the time, d	ause(s) : late and	and manr place, an	ner as stat d due to t	ed. he cause(s)		
	To the Hospital or Attendi within 24 hours effer death. To the Funerel Director: A completely filled in by the to	Mec	29b. Signature and tile of certifie	4				License nu									
	- ≯ F 8) MB			1	Mes C	715	a	2	.au. Date	signed (Month, Da	iy, rear)		
1	U		1 WW				7	MF	2216	> (171	100	3		
			30. Name and address of person	who completed cause	se of death (Iter	m 23a) (Tyoe, (Print)	N. M	1 1		W.	1.0	,	12	200		
30	and parts		31. Date filed (Month, Day, Year)	MULTER	IOI	-1 77	MCP	MAIL	N A	MANA	UV	weg	1 1	710	208	32	
35.0	Sta Registr		MAY 1 9	2006	Registrar's Signa	M Los	4000	•				Į					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** PEGGY PARK 10, 2006 /Medical MAY 4:30P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GAITHERSBURG
If Under 1 Year If Under 24 Hrs ODENDHAL AVE MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🖫 F 216 64 7089 81 Director Yrs AUG 12,1924 S. KOREA Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location ir than "natural", or Items 23a or 28a-f ehow the Medical Examinar must be notified at 10d. Inside City Limits Director MD MONTGOMERY Yes 2□No GAITHERSBURG 10e. Street and Number 10f Zio Code 10g. Citizen of What Country? death \ by Funerai 101 ODENDHAL AVE APT 1017 20877 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡No 3 ☐ Widowed 4 ☐ Divorced Specify: Specify: ASIAN Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE PRIVATE 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Haalth and Mental H. ant: If itsm 27 Is marked ott 18. Mother's Name (First, Middle, Maiden Sun MAN SUNG PARK KIM Y MOON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL MORGESON (DAUGHTER) 61 BRASS EAGLE CT SYKESVILLE MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Detay: ö permit. Page Department of Important: If any injury or once. NORBECK MEMORIAL 5/13/06 OLNEY 22. Name and Address of Facility CHARLES HINDS FUNERAL SERV 21. Signature of Funeral Se 12303 KAYAK DR UPPER MARLBORO MD 20772 23a. Part1. Enter the disease, or can shock, or heart failure. List only implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ene cause on each line. Immediate Cause (Final Physician BLADDER disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): certificate be executed been signed by the attanding physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has was an autopsy performed? 1 ☐ Yes 1 Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred To the Mospital or Attending F within 24 hours after death. To the Funeral Director: After Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and Mile 29c. License number 29d. Date signed (Month, Day, Year) D35635 MAY 12, 2006 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., JOSEPH KAPLAN 18111 PRINCE PHILIP DR, OLNEY MD 20832 31. Date filed (Month, Day, Year) State MAY 1 5 2006 Registrar

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State of Maryland / Department of Health and	Mental Hygiene	0.0	-
0 40 4 5 4		-	-4

		1 - State Registrar	epartment of Health and I Certificate of Death	R	leg. No.	153
	ician dical		RVIS	2. Date of Dea Month May	21 2006 2	of Death
Exar	niner	4a. Facility Name (If not institution, give street and number) St. Catherine's Nursing Center	4b. City, Town, or Location of Death Emmitsburg	h	4c. County of Death Frederick Coun	tv
Funer Direct		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 229–09–5098 1□ M 2ÅF 83 Y			9. Birthplace (State	
death with the Maryland ms 23a or 28e-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town Maryland Frederick County Emmits			10d. Inside	City Limits
with the	Il Director		10f. Zip Code 21727		10g. Citizen of What Country? Inited States	
ē 5	by Funeral	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
* # # # #	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	Decedent's Usual Occupation Give kind of work done during most of wor life. DO NOT use retired) gal secretary	rking	16b. Kind of Business/Industry law firm	
Maryland Z d 2 should be filed th and Mental Hygi ? Is marked other treumetic event,	To Be C	Robert Temple Burgess, Sr.	Elizal	beth Purv		
C 20 01 =		Alan C. Purvis / son 104	Mailing Address (Street and Number or Ru 45 Cool Spring Drive	e Westmi	inster, Md. 21157	,
Baltimore, permit. Pages 1 a Department of Hee Importent: If item		1 X Burial 2 Cremation 3 D Removal from State cemetery	Disposition (Name of cormatory or other place) d Cemetery 22. Name and Address of Facility	26	20c, Location - City or Town, State Charlottesville,	۷a.
ifficate be executed ifficate be executed ifficate be executed ifficate be executed ifficate be executed ifficate be executed as the burial-transit	la la la la la la la la la la la la la l		nced Almen 1):			ate etween
Hecords, P.O. Box 68/60, The law requires that the death certificate be ex the has been signed by the attending physicien. Aage 2 should be detached for use as the burnal	ian/Me		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day	Year
COTGS, P. w requires that the second signed by should be detailed.	d by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		bacco use contribute to the cause o	
	Comp			24a. Was a autop: perform		s available cause of
VITS sicien certifi irector	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	patient 3 DOA Other: 4 Nursing H		ne) ence 6 Other (Specify) ow injury occurred	
Division of To the Hospitel or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	ertifica	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 □ Yes 2 □ No m, street, factory, office	28f. Location (S City or Town	treet and Number or Rural Route No n, State)	ım <i>ber</i> ,
To the Hospitel within 24 hours a To the Funerel completely filled	Medicai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	for investigation, in my opinion, death occu	urred at the time, d	late and place, and due to the cause	
		· Un aud	29c. License number		29d. Date signed (Month, Day, Year)	
٨	2	30. Name and address of person who completed cause of death (Item 23a) (I Alan L. Carroll, M.D. 310 Sout)		mitsburg	, Maryland 21727	

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Alan L. Carroll, M.D. 310 South Seton Avenue

Date filed (Month, Day, Year) 32 Registrar's Signature

ORIGINAL

06-03072 Jason A. Quarles

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate of Death	Re	eg. No	106 6/5
Physicia	_	1. Decedent's Name (First, Middle,Last)	Date of Dea Month	th Day Year	3. Time of Death
Medical Examir		Jason A Quarles	May 6, 20	06	2320 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Peninsula Regional Medical Center 4b. City, Town, or Location of Death Salisbury	1	4c. County of Wicomico	
٠٠,	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	s. 8. Date of Bir	rth(MM/DD/YYYY)	Birthplace (State or
Funeral Director	- 1	Months Days Hours Min	1.		Foreign Country) Indiana
		305-98-3997 1 ▼ M 2 F 28 Yrs. Usual Residence of Decedent	Dec 13	, 19//	- // Ilid Latta
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
* .	<u>_</u>	Maryland Worcester Pocomoke			1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code	l l	0g. Citizen of Wha	
the N		3 Clarke Ave. 21851	1	United St	
death with the Maryland or items 23a or 28a-f sho must be notified at once	ਹ।	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Single Married Armed Forces? 14. Never Married Armed Forces? 15. Was Decedent of Hispanic Origin? (Single Married Armed Forces)		o- 14. Race - White,	American Indian, Black, etc.
r death	Fun	Never Married 2 Married 1 X Yes 2 No		Specify: [Thita
5-0036 led within 72 hours after death with the Maryland Hygiene. I other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	3	3 Widowed 4 Divorced If Yes, Give Yes 96-2006 1 Yes 2 No specify: 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of Vertical Complete)	work done	16b. Kind of Busi	
2 hou	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	ired)		
D36 thin 7 ne.	힐	12 Sailor		United S	States Navy
5-00 led with Hygiene other the Me	O	The fall of traine () and the fall of the	e (First, Middle,	Maiden Surname)	1:
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Edward Quarles Kathy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Bural Bouta Nur		State Zin Code)
D 2 Should and M 7 is m	1	Kathy Quarles/Mother 2396 N 425 W, Danvill			, Glate, Zip Gode)
Baltimore, MD 21218 Baltimore, MD 21218 Department of Health and Mental I important: If item 27 is marked injury or other transmatic event,	- 1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	_	City or Town, State
_ ಕ್ಷ್ಮ ಕೃಷ್ಣ ದ	- 1	1 X Burial 2 Cremation 3 X Removal from State crematory or other place)	13-06	Indiana	oolis, IN
Baltimon permit. Pag Department Important:		4 Donation 5 Other Specify: Crown Hill 5- 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thibadeau Mortuary			JOILES, IN
Balti Permit. Departu Import		MO0956 1933 Gist Ave., LL	, Silver	Spring.	MD 20910 _
Physician		M00956 I 933 Gist Ave., LL 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory an	rest, shock, or hear	t Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a Multiple Injuries			Death
		or condition resulting in death) Due to (or as a consequence of):			
	ā	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	aminer	cause. Enter Underlying Cause (Disease or injury that initiated c.			
cecuted 1 and - transit	ШĬ	events resulting in death) Last Due to (or as a consequence of):			
execu an and	Physician/Medical	UNPENDED AMENDED			
760, ficate be exe g physician the burial	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of o	delivery
687 ertific ding p e as th	an/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	ancy	Month	Day Year
Box 68's e death certificate attending ed for use as	/sic	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)			
D. E t the d by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	tobacco use contrib	oute to the cause of death?
P.C es tha signed be det	d by		1 Ye	es 2 🗸 No 3	Probably 4 Unknown
rds, requir been s	Completed		24a. Was		ere autopsy findings available ior to completion of cause of
e law te has ge 2 s	Ę.			ormed? de	eath? ✔ Yes 2 No
II Re		25. Was case referred to medical 26. Place of Death (Check			
Vita ysicia this ce	To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursi	ing Home 5	Residence 6	Other:
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the and the death After this certificate has been signed by led in by the funeral director, page 2 should be detach	n:T	A. (Month) Poly Year)		how injury occurre	
ion ttendi death rtor: / the f	atio	2 Accident Investigation			
IVIS lor A after Direct	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway	or Town,	State)	r or Rural Route Number, City
Spita hours neeral y fille		4 Homicide Telephonic Major Road / Highway		ypass, Fruitlar	
Division of Vital Records, P.O. Box 68760, vitin 10 the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ical	29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	at the time, date	e and place, and du	ue to the cause(s)
To 1 To 1	Medical	29b Signature and tile of certifier 29c. License number		29d. Date signe	d (Month, Day, Year)
9+1	-	O.C.M.E.		May 7, 2006	6
		30 Name and address of person who commeted cause of death (Item 23a)			
		Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201		
	tate	MISH / 111101 POW-A-A-A A-P ASSESSED			
Regis	trar	MAT I I ZUUD BLAWS ST.			

Donald R. Russell 06-02999 /06-03081

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day 3, 2006 1225 hrs Donald Raymond Russell **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Charles 2541 Charter Oak Drive Waldorf If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** oreign Country)New York Months Davs Hours July 22, 1941 Director 115-32-1231 64 $_{1}X_{M}$ 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1X Yes 2 No Baltimore City 23a or 28a-f show notified at once. Maryland death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21216 1406 N. Dukeland Street 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Mantal Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2X No Yes Specify: White If Yes. Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divorced hours after à 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "1 injury or other traumatic event, the Medical E MD 21215-0036 Courrier Service Courrier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (unk) (unk) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, informant's Name/Relationship (Type, Print) 5352 Greenbridge Road Dayton, MD 21036 Patrick Perez/friend 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) Burial 2 XCremation 3 Removal from State 05/15/06 Beltsville, Maryland Chesapeake Crematory Other Specify Donation 5 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Heckrotte, P.A. Clarksville, MO1251Beverly L. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Death M dical a. Asphyxia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate ner cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and ca e attending physician a for use as the burial AMENDED UNPENDED The law requires that the death certificate be Physician/Medi Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Yes 2 No 9 Unknown for 9 Unknown as been signed by the a should be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o \$ 1 Yes 2 ✓ No 3 Probably 4 Unknown Division of Vital Records, P. Atherosclerotic Cardiovascular Disease Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy r this certificate has b performed? death? 2 No Yes 2 1 🗸 Yes No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 DOA Residence 6 🗸 Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 V Yes ဥ No 28a. Date of Injury (Month, Day, Year) Unknown 28c. Injury at Work? 28d. Describe how injury occurred After 28b. Time of Injury 27. Manner of Death Subject asphyxiated Unknown within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Natural Yes 2 ✔ No Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) 1406 Dukeland St., Baltimore, MD Suicide (Specify) Townhouse / Rowhouse determined 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. May 4, 2006 elf 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD

32. Figistrar's Signature

MILLE

2006

State

Registrar

31. Date filed (Month, Day, Year) 5

	•	1 - For State Registrar	State of Maryla		artment of rtificate of		d Mental Hy	/giene () ()	6 6750
Physicia /Medic		Decedent's Name (First, Middle, Last HELEN VIRGINI	A RAINES				2. Date of De Month MAY 14	eath Day	3. Time of Death 8:54 A
Examin	er	4a. Facility Name (If not institution, give CIVISTA MEDICAL 5. Social Security Number 6. Se	CENTER	s. last birthday)	4b. City, Town, I,APL,A If Under 1 Yea			4c. County o	
uneral rector		577-24-8652 Usual Residence of Decedent 10a. State 10b. County	™ ЖЕГ 83	Yrs.	Months Days	Hours N	Hrs. 8. Date of Bi Min. (Month, D. 08-13-	ay, Year) -1922 W	ashington, D.
28a-f aho	rector	Virginia Fairfax 10e. Street and Number		lexandı				10g. Citizen of WI	1 ☐ Yes 2 🔼
if item 27 is marked other then "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examinat must be notified at	by Funeral Director	4100 Olympic Way 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 器 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates:		22		? (Specify Yes or No uerto Rican, etc.)	USA	- American Indian, White, etc.
sther then "natur ant, the Medical	e Completed by	15. Decedent's Edi (Specify onfy highest grad Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last)		(Give	dent's Usual Occu kind of work done DO NOT use retin ata Entr	y Clerk		16b. Kind of Bus Private Maiden Sumame	
s marked o	To B	Hugh Spindle 19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailir	ng Address (Stree	Ethe1	May Clark		
Importent: if item 27 is mar any injury or other traumati once.		Patricia Bradford/ 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	20b.	11675 Place of Dispo		Jesse Pl		оу, Md. 2	0062 ity or Town, State
any inju		21. Signature of Funeral Service Licens Many Redgm	em MC137		Name and Address		c. 4111 P	enn.,Ave.	20746 Suitland,Md
physician and the burial-transit the burial-transit	dical Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, harry, leading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a conse b. PREUMO: Due to (or as a conse c. Fail we Due to (or as a conse d.	nia quones off. to -	tanive				Interval Between Onset and Death
Cost	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. tf yes, outcome of pregr 1 \(\subseteq \subseteq \text{i/ye} \) birth 2 \(\subseteq \subseteq \text{Fet} \) 4 \(\subseteq \subseteq \text{i/me of} \) 9 \(\subseteq \subseteq \text{i/me of} \)	al death 3	Ectopic pregnand Other (specify)	sy		23d. Date Monti	
e d pe d	þ	Part II. Other significant conditions co	ntributing to death but not re	sulting in the ur	nderlying cause g	ven in Part I.	23e. Did t	A 4	ute to the cause of death?
certificate has been rector, page 2 shoul	Completed						24a. Was autoj pendo 1 Yes	psy prior dea	ore autopsy findings availab or to completion of cause of ath?] Yes 2 [] No
is certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 npatient 2	☐ ER/Outpatien	t 3 DOA Ot	har	Death Check only o		10
After t	Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 - 14012111		dence 6 Other	
To the Funeral Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ify)			City or To	wn, State)	or Rural Route Number,
the Fund	Medical	29a. Certifier 1 Certifying Phy 2 Madical Exami	sician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the trestigation, in my	me, date and pla opinion, death or	ace, and due to the courred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
	2	29b. Signature and title of certifier	MD		29c. Licen	se number		29d. Date signed (h a

			For State Registrar	State of	Marylar	nd / Depa <i>Cer</i>	rtment of F	lealth and <mark>I</mark> Death		gienez ()	06	167	57
10	Ext. Ser		1. Decedent's Name (First, Middle, La	st)					2. Date of Dea	ath		3. Time of D	Death
	Physicia /Medic		Tina A	nneMar:	ie	Ridle	₽Y		Month 04	29	2006	5:47	'a ^M
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of Death	1	4c. County	of Death		
			Prince Georges				Cheve					eorge	
	Funeral		5. Social Security Number 6. S 120-56-0603	ex 7. □M 252(F	Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Day	v, Year)	Countr	ice (State or y)	Foreign
	Director	1	Usual Residence of Decedent		32				02/21	/1974	New	York	
	deeth with the Maryland ms 23s or 28a-f show rmst ke notified at		10a. State 10b. County		10c. C	ity, Town or Lo	cation				100	d. Inside City	y Limits
	Mar Ba-fst	iò	MD Prince	George	es C	apital	Height	ts				1 ⊡ ¥Yes	2 🗌 No
	th the	Jire	10e. Street and Number	_			10f. Zip Code			10g. Citizen of \	What Countr	y?	
	23a	rai	2004 Thyrring	Ct.			207	747		USA	1		
	er de	Funeral Director	11. Marital Status	12. Was Deced Armed Force	es?	J.S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ck, White, et		
30	within 72 hours after ene. then "natural", or Ite to Medical Ever, in e	by F	1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date		1	☐ Yes 2 🗷 No	Specify:		Specify	y: Blac	ck	
2-0030	thou stura		15. Decedent's E		33.	16a. Deced	ent's Usual Occup	ation	1	16b. Kind of Be			
2	nin 72 In In	ompieted	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4	0.51	(Give	kind of work done OO NOT use retired	during most of world)	king	700.11110.07.01	301100011100	istry .	
7	e filed within at Hygiene. I other then "	mo;	12	5+	.Or 3+)	soc	cial wor	ker		_socia	l se	rvvic	es
	be filed within 72 hours after deeth with the Marylan ital Hygiene. Indoorber then "natural", or Items 23a or 28a-f show event, Ite Medical Evar, inserment be notified at	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,				
yıand	2 should be and Mental Is markad raumatic ev	일	Ronald Brown					Kathlee	en A. R	idley			
Mar	s 1 and 2 should f Health and Mer item 27 Is marks other traumatic		19a. Informant's Name/Relationship (_			and Number or Ru					
2 ()	l and lealth im 27		Kenneth Wood,	Jr-fian		2004	Thyrri	ing Ct.					0747
0	Pages 1 ar nent of Hea int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2℃ remation 3 ☐		ale		sition (Name of natory or other place	1	Date	20c. Location -	,		00.0
Baitimor	t. Pa rtmen rtant: njury		*4 □Donation 5 □Other (Special		L		Hill Cr			Coloni		∍ight	s, V
n n	permit. Pages Department of Important: If it any Injury or o		21. Signature of Juneral Service Lice	Simi	reve	²² A	Name and Addre 1exander 538 Marl	ss of Facility S. Pope boro Pike	Funeral	Homes,	P.A.	20747	i
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	sed the dea	th. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory are	rest,	, A	Approximate Interval Betw	nen .
	Physician		Immediate Cause (Final disease or condition	0 -		Tame	01/11/1	th me	tasta	EPC	Č	Onset and De	eath
	/Medical Examiner		resulting in death)	Due to (or	as a conse	quence of):		1111	10310	30			
	LAGITITIES .	_	Sequentially list conditions, if any, leading to immediate	b. Brai	nr	neta	stase	25					
	ed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consec	quence ot):							
	executed n and ial-transit	хап	that initiated events resulting in death) Last	cDue to (or	as a conse	nuence of):							
8/60	ficate be executed physician and s the burial-transit	aiE	l										
200	ficate g physics the	edicai		d									
ZOZ	wrequires that the death certif been signed by the attending should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco						23d. Dat	te of delivery	/	
מ	death e atten ed for u	icia	in the past 12 months? 1 ☐ Yes 2 🗷 No	4 Pregnar	h 2∐Feta ntattime of		Ectopic pregnancy Other (specify)						ear
5	by th	hys	9 Unknown	9□ Unknow	'n								
Š,	requires that the teen signed by th hould be detache	ру Р	Part II. Other significant conditions	contributing to dea	th but not re	sulting in the ur	derlying cause give	en in Part I.	23e. Did to	bacco use conti	ribute to the	cause of de	ath?
ecords	equir en si ould l								1 🗆 Y	es 2 No	3 Probab	bly 4 ∐Un	iknown
ပ္	2 2	ple							24a. Was a autops		Were autops	sy findings av	vailable
r	The zate ha	Completed							perfor	med?	death? 1 ☐ Yes 2		
Vital	ysician: The lav is certificate has director, page 2	Be	25. Was case referred to medical examiner?						th (Check only or	16)			
0	× × ×	7	1 ☐ Yes 2 No	Hospital:		ER/Outpatien		4 Nursing H	ome 5 🗆 Reside				
	ding Phys J. After this funeral dii	ion	27. Manner of Death 1 Natural 5 Pending		Day Year)	28b. Time of Injury	28c. Injun Work		28d. Describe h	ow injury occurr	ed		
DIVISION	death death stor:	icat	2 Accident investigatio 3 Suicide 6 Could not b	e Geo Diese o	Flaire Ath	omo form etc	M 1 []	Yes 2 □No	OR Location /C	Areas and Assert			
2	l or A after Direction by	ertification	4 ☐ Homicide determined	building	, etc. (Speci	fy)	et, factory, office		28f. Location (Si City or Town	n, State)	er or Murai P	soute Numbe	ar,
	spita iours neral	O	29a. Certifier 1 ☑ Certifying Pl	nysicien: To the b	est of my kn	owledge, death	occurred at the tin	ne, date and place	and due to the c	ause(s) and ma	nner as stat	ted.	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Example)	niner: On the bas and manne	is of examina	ation and/or inv	estigation, in my o	pinion, death occur	rred at the time, d	late and place, a	and due to th	ne cause(s)	
	To th withir To th	Me	29b. Signature and little of certifler				29c. License	e number	2	29d. Date signed	d (Month, Da	ay, Year)	
			I HUIXI		uso		D05	5220		4/29/	06		
	(10)		30. Name and address of person who	4		m 23a) (Type, I	Print)			1-11	- 01		
			TERM MATIN	J 300	OHIC	vo ga	Cher	evly n	NO 207	85.			
	Sta		31. Date filed (Month, Day, Year) MAY 1 6 2006	32. Reg	jistrar's Sign	ature	2.)					
	Registr	ar	MM1 T 0 7000	proces	1 1	14							

			Please	Type or Prin							•		•	le.	
			For State Registrer	State of Ma	aryland				ealth a D <i>eath</i>		ental H	ygier Reg. 1	201) 6	16758
	Physicia	an	Decedent's Name (First, Middle, Last M	. ATIQUR	RAHMA	N			,,,		2. Date of D Month MAX		Day 2006	Year	3. Time of Death
	/Medic Examin	A 1	4a. Facility Name (If not institution, give	street and number)			4b. City		Location of	of Death	PIAL		4c. County of		6:05 A [™]
	Funeral		NATIONAL NAVAL ME 5. Social Security Number unk6. Se		e (In yrs. la	ast birthday)	If Und	er 1 Year	ESDA If Under Hours	24 Hrs. Min.	8. Date of 8 (Month, 2 3-1-	lirth Day Yea		9. Birth	MERY place (State or Foreigr qtry)
ъ¢	Director		Usual Residence of Decedent	201	79	Yrs.					3-1-	192	/	Inc	ııa
	ith the Marylar or 28a-f ehow	ctor	Md. Montgome	ery		, Town or Lo hesda									10d. Inside City Limits 1 ☐ Yes 2 No
	3a or 28	I Dire	10e. Street and Number 9506 Old George	town Rd	•			ip Code 0814				-	Citizen of W		•
2	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: if item 27 is marked other than "naturel", or iteme 23a or 28a-f show entry fourty or other traumatic event, the Madical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔯 If If Yes, Give			f Yes, sp	edent of Hi ecify Cuba 2 No	ispanic Ori n, Mexicar Specify:	i, Puerto	crfy Yes or N Rican, etc.)	10-		, White,	can Indian, etc. Sian
	in 72 hour n "naturel" Nadicel Ex	Completed b	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)				kind of w DO NOT	ork done d use retired	during mos	t of worki	ng	16b.	. Kind of Bus		
7 7 7	2 should be fited within and Mental Hygiene. Is marked other than sumatic event, the Marental Comments of the Marental Co	Be Com	17. Father's Name (First, Middle, Last) Ubad-UR-Rahman	4	Sahi	Photo b	ogra	pher	18. Mothe		(First, Midd	le, Maid)	
viai y ia	12 should be h and Mental 7 is marked of traumatic ev	To	19a. Informant's Name/Relationship (7) Atif Atiq - so:							er or Rura	l Route Num	ber, Cit		State, Zij	o Code) , Md . 20814
ב. ס	Pages 1 end nent of Heelth int: if item 27 iry or other tr		20a. Method of Disposition 1 ABurial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	ce	ace of Dispo metery, crer	sition (Na	ame of other place	e)		ate	20c.	Location - (City or T	
משווו	permit. P Departme Importan eny injur		21. Signature of Funeral Service Licens		064	22	. Name	and Addres	ss of Facili	y Un:	ivers	al	Morti	ary	
,00	Physician /Medical Examiner portion and portional portional portional	cal Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each li	ne. ASTAT a consequ a consequ	ence of):				cardiac	respiratory	allest,			Approximate Interval Between Onset and Death
O. BOX 007	The law requires that the death certificate be standing physicia at a been signed by the attanding physicia bagae 2 should be detached for use as the burn	Physician/Medic	IF FEMALE:	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic Other (pregnancy specify)					23d. Date Mon		ery Day Year
oras, r.	quires that 1 en signed by tuld be deta	by	Part II. Other significent conditions co	ontributing to death b	ut not resu	Iting in the u	nderlying	cause give	en in Part I				3.7		the cause of death?
נו	The law resata hes becase page 2 sho	Completed										topsy formed	? d	rior to co	opsy findings available impletion of cause of
	Physician: this certific ral director,	To Be	25. Was case reterred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	nt 2□E	ER/Outpatier	nt 3 🗆 [Othe	or:		n (Check only		6 □Othe	r (Speci	fv)
vision o	il or Attending Physicien: The lavarien death. Director: After this certificate hes d in by the funeral director, page 2.	ü.	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o Injury		28c. Injury Work	y at	:	28d. Describ			-	
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certificat	4 Homicide determined	building, et	c. (Specify						City or T	own, St	ate)		al Route Number,
	To the Hosp within 24 ho To the Func completely f	edical	29a. Certifier 1X Certifying Ph (Check only 2 Medical Exam one)	ysicien: To the best iner: On the basis o and manner st	examinat	viedge, deat ion and/or in	n occurre vestigatio	a at the timen, in my of	ne, date ar pinion, dea	nd place, ath occurr	and due to the	e, date a	e(s) and mar and place, a	ner as s nd due t	stated. o the cause(s)
)	Mithi To t	Σ	29b. Signature and title of certifier	(1-			2	9c. License	e number 6746	(OR)			Date signed		
	(2)		30. Name and address of person who	completed cause of c	leath (Item	23а) (Туре,	Print)				VAL ME		AL CEN	, -	106

DHMH 17 Rev 1/2001

State Registrar LEE VANCE LCDR
31. Date filed (Month, Day, Year)
MAY 1 5 2006

MC

USN

BETHESDA MD 20889-5600

			For State	State	of Mar	yland / D	epa Cer	irtment of H	ealth a Death	nd M	ental H	ygien Reg. N	414	6	167	59
			Registrar 1. Decedent's Name (First, Middle	, Last)							2. Date of D		0.		3. Time of E	Death
	Physicia		Jack Lee Rose	nhero							May 1	20	006	Year	5:00) PM
	/Medic		4a. Fecility Name (If not institution		ımber)			4b. City, Town, or	Location of				c. County o	f Death	3.00	
	Examin	er	3702 Longfellow					Hyattsvi		204			rince		rge¹s	
-	-		5. Social Security Number	6. Sex	7. Age (In yrs. last birtl	hdav)	If Under 1 Year	If Under 2	4 Hrs.	8. Date of B	irth			lace (State or	Foreign
	Funeral Director		216-46-0439	1 X □M 2□F	3.,		rs.	Months Days	Hours	Min.	(Month, E	Jan Van			ington,	
			Usual Residence of Decedent		L						1102	,	20 10 1	10.011	21160011	, 2.0
	ow s		10a. State 10b. County		1	0c. City, Town	or Lo	cation		•				1	0d. Inside City	Limits
	Man	ţ	Maryland Prince	George's		Hyattsv	<i>7</i> i 1	1e							1 XYes	2 🗌 No
	the	e Se	10e. Street and Number	CCC18C C		11) 4223 (10f. Zip Code				10g. C	itizen of Wh	hat Coun	try?	
	3a or	۵	3702 Longfellow	Street				20782				USA				
	ns 2	Funeral Directo	11. Marital Status	12. Was De	cedent Ev	er in U.S.	13. \	Vas Decedent of H	ispanic Orig	in? (Spe	cify Yes or N		14. Race	- Americ	an Indian,	
_	fter o	F	1X Never Married 2 Marr		2X No			Yes, specify Cuba		Puerto f	Rican, etc.)	i		, White,		
	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or				∐Yes 2∐XNo	Specify:				Specify.	Vhite	2	
5	2 ho	Completed	15. Deceden			16a.	Deced	lent's Usual Occup	ation	,		16b.	Kind of Bus			
2	n n N	ple	(Specify only highest Elementary/Secondary (0-12)	1	(1-4or 5+)		life. L	kind of work done o OO NOT use retired	during most i)	of workir	ng					
7	r the	E	Listinshialy/occurrency (o 12)	Comage			sin	ess Owner	•			Gro	ocery	Sto	re	
5	othe ent,	a)	17. Father's Name (First, Middle,	Last)					18. Mother	's Name	(First, Middl	e, Maide	n Sumame)		
/land	ld be lenta ked ic ev	To B	David Rosenberg						Eliza	beth					(ur	ık)
ary	shound M	-	19a. Informant's Name/Relations	hip (Type, Print)		19b.	Mailin	g Address (Street	and Number	r or Rura	l Route Num	ber, City	or Town, S	tate, Zip	Code)	
Ž	Ith a 27 is		Grace Rosenbloo	m/domosti	ia na	rtnor 5	370	2 Longfol	1017 S	+ U	watter	7 i 112	MD	2075	82	
ก	Hea Hea tem		20a. Method of Disposition	my domest.	с ра	20b. Place of	Dispo	sition (Name of			ate		Location - C			
2	ages nt of t: If I		1 Burial 2 Toremation 4 Donation 5 Other (S		n State			natory or other place ke Cremat		5/15	/06	Ro 1 t	- evri 11	la 1	Marylar	hd
saltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or tems 23a or 28a-f show any injury or other traumatic event, It a Medical Examine must be notified at once.	1	21. Signature of Funeral Service		1.	onesar						1				Iu
n D	permi Depar Impoi any Ir once.		21. Signature of Furioral Solvico	277 - 1/2	11		G	Name and Address Home	Crem	atio	n Serv	ice	P.O.	. Box	x 7 84	
			23a. Part T. Enter the disease, or	HOU		MO1251	L B	everly L.	_Heck	rott	e, P./	1. C	Larksı	7 111 6	Approximate	
			shock, or heart failure. List	only one cause on	each line.		iot ent	er the mode of dyin	g, such as c	ardiac o	respiratory	arrest,			Interval Betwo	een
	Physician		Immediate Cause (Final disease or condition	a.		Pros	377	one co	ance	1					Officer and Dr	Zatti
	/Medical		resulting in death)	Due to	o (or as a	consequence o	of):									
	Examiner		Sequentially list conditions	b. ———												
-	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to	o (or as a	consequence o	of):									
	cuter	am	that initiated events	с												
Ć	an a		resulting in death) Last	Due to	o (or as a	consequence o	of):									
2/60 8/60	cate be executed physician and the burial-transit	dicai		d												
Ö											-	1				
Z D D	death certifi e attending id for use as	Iclan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o		pregnancy □Fetal death	3 L	Ectopic pregnancy					23d. Date	of delive	ry	
<u>מ</u>	death d for	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	nant at tir	me of death		Other (specify)					Mont	h	Day Ye	ar
j	t the	Physi	9 🗆 Unknown	9□ Unk	nown											
ν, L	law requires that the death certif as been signed by the attending 2 should be detached for use a:	by Р	Part II. Other significant condition			-			en in Part I.		23e. Did	tobacco	use contrib	oute to th	e cause of dea	ath?
ğ	quire n sig ald b		hepare	cins	UFF	icien	cu				1 🗆	Yes 2	2 □ No 3	Prob	ably	known
Hecord	w rec	ompleted	·					•			24a. Wa	s an	24b. W	ere autor	sy findings av	vailable
E C	0 - 0	m									aut	opsy formed?	pri de	or to con ath?	npletion of cau	use of
Ö	iclan: Th certificate rector, pag	O				·					1 Tes	22W	0 1	Yes	2 No	
VItal	Physiclan: this certific ral director,	Be	25. Was case referred to medica examiner?	Hospital:				Oth	or		(Check only	-				
O	Phys this al di	2	1 Yes 2 No 27. Manner of Beath	1	Inpatient of Injury	2 ☐ ER/Out 28b. T		1 3LI DUA	4 LI Nur		ne # Res				")	
ב	iding Phy th. : After this funeral o	lo	1 Natural 5 ☐ Pendir	g (Mo	nth, Day	Year) In	njury	Worl	k? Yes 2 □ N	- 1	.ou. Describe	5 110 W 111 J	ary occurre	4		
<u>s</u>	ttend death ttor: the	ical	2 Accident investi	not be	a of laive	. At home for			163 2 1	_	194 Lagation	(Ctract o	and Alexandra	D	I Davida Alicada	
UIVISION	al or Attending F s after death. if Director: After id in by the funera	Certification;	4 ☐ Homicide determ	ined 286. Flat buil	ding, etc.	(Specify)	m, su	eet, factory, office			City or To			or Hura	l Route Numbe	эr,
_	To the Hospital of within 24 hours at To the Funeral D completely filled in		00- 0-44	n						<u> </u>						
	Hosp 4 ho Fune Bly f	edical	(Check only 72 Medical	ig Physicien: To the Examiner: On the	basis of e	xamination and	, death d/or in	n occurred at the tin vestigation, in my o	ne, date and pinion, death	i place, a h occurre	and due to the	e cause(: e, date ar	s) and mani nd place, an	ner as sta nd due to	ated. the cause(s)	
	the hin 2 the nplet	Med	one)	and ma	nner state	od.										
	7 vit	-	29b. Signature and title of certifie		000	3700		29c. Licensi	o number	111-	>		ate signed	_	- 6	,
_ /				W. On				1-3	, < >	17	2				500	
3/	Jm		30. Name and address of person	who completed car	use of dea	th (Item 23a) (Туре,	Print) CSAC	NIN	U. C	TI	5	Ch 1006	dre	A HA	n
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	Sta Registr		31. Date filed (Month, Day, Year) M \(\Delta \begin{align*} 1 \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		egistrar'	s Signature	1	marks &								

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Year Physician 11:00 P.M. 00 Alma Rupp /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner AlleGAN SACred if Under 1 Year If Under 24 Hrs. HEART HOSPITAI Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2MF Months Days Hours Yrs. 09-Apr-1916 Maryland Director <u> 213-09-8576</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "netural, or items 23a or 28a-f eho 1 XYes 2 □ No Frostburg Maryland Allegany Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 196 1/2 Glenn Street 21532 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) other than Elementary/Secondary (0-12) homemaker permit. Peges 1 and 2 should be filed to Department of Health and Mental Hygie importent: If item 27 is marked other 11 eny injury or other traumatic event, that once. homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Heneghan 2 Jesse Yantz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 196 1/2 Glenn Street 21532 Maryland Frostburg husband John C. Rupp 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 17-May-2006 Frostburg Maryland Frostburg Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 ohn 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BILATENAL PNEUMONIA SYX DAYS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day signed by the atte 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform 1 ☐ Yes 2 ☐ No 2 No certificate 1 Yes Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ٩ 1 ☐ Yes this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death.
To the Funerel Director: At completely filled in by the fu death. investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dav. Year) 29b. Signature and title of control 29c. License number DYY283 (MARYLANI) MAY Kore 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1068 NATIONAL HIGHWAY LAVALE, MAKILAND 21502 R. MUEN, MD JAMEZ 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State MAY 1 5 2006 Registrar

			For State Registrar	State of Ma		/ Depa		t of H			ental Hy	Reg. No.	006	16761
			1. Decedent's Name (First, Middle, La	st)							2. Date of De.	ath Day	Year	3. Time of Death
	Physicia /Medic		Wilbert	(1)	(NMN		Renn	ie			May	05	2006	14260 M
	Examin		4a. Facility Name (If not institution, giv	street and number)			4b. City,	Town, or	Location of	f Death			ounty of Death	
			Memorial Hosp	ital			C	um	berl	and	£	1	Allega	anv
	Funeral		Social Security Number		e (In yrs. las	t birthday)	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bird	th v Year	9. Birtin Cou	place (State or Foreign
	Director		217-03-2049	M 2□F	90	Yrs.	WIOTILITS	Days	Tiodis		8. Date of Bird (Month, Da 12/10/	1915		yland
	P .		Usual Residence of Decedent											
	rylar		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	a-f	cto	MD Alle	gany		C	umbei	cland	1					1)∑Yes 2 ☐ No
	th th	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Cou	ntry?
	23a	ai	503 Eichner	Avenue					21502	2			USA	
	dea arms	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Deced	dent of Hi	spanic Orig	in? (Spe	cify Yes or No Rican, etc.)	- 14	Race - Ameri Black, White,	
9	or it	F	1 Never Married 2 X Married	1 ∑XYes 2 ☐ N If Yes, Give	1945	<u> </u>	1 🗆 Yes		Specify:		,		pecify:	
8	irel',	d by	3 Widowed 4 Divorced	Year or Dates:	1946)							W	hite
Š	within 72 hours after death with the Maryland ans. Then "naturel", or flems 23a or 28a-f ehow he Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gra			(Give	dent's Usua kind of wo	rk done d	luring most	of workii	ng	16b. Kind	of Business/In	dustry
7	ithin nen.	du	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. i	DO NOT u		,					
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<u>n</u>	be fi	Be	17. Father's Name (First, Middle, Last,								(First, Middle,	-		
100	2 should be filed within and Mental Hygiene. Ie marked other then aumatic event, the Mannatic event ev	၉	Unknown							rah			ennie	
Maryland 21215-0036	2 sh and 10 m	Ì	19a. Informant's Name/Relationship (1		-				I Route Numbe			
	and lealth m 27 her tr		Paul Fred Farrel	/ step-s			TO SHARE STORY	OPERANT PROPERTY.	venue	-	mberlar ate			
ore	Pages 1 nent of H int: If ite iry or otl		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	сеп	ce of Disponetery, crer	natory or o	ther place					tion - City or T	
Baltimore,		ļ	4 □ Donation □ Other (Special		Cumb						/2006		erland	
alt	permit. Departn Imports eny Inju		21. Signature of Funeral Service Lice	1500	_							-		Home, P.A.
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	Physician /Medical Examiner	iner	23a. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Source tielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury)	a. Chronic Due to (or as	a conseque	Stru nce of):					Tyr		se	Approximate Interval Between Onset and Death
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9 ×	ding Se as	Me	IF FEMALE:	23c. If yes, outcome	of pregnanc	ev.						22.	t. Data of dalis	
P.O. Box	The law requires thet the death certificat sie hes been signed by the attending phypage 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3	Ectopic pi Other (sp					230	d. Date of delive Month	Day Year
٠, ٦	es the igned be det	by P	Part II. Other significant conditions of	ontributing to death b	ut not resulti	ing in the u	nderlying o	ause give	en in Part I.		23e. Did to	obacco use	contribute to t	he cause of death?
Records,	w require been sig should b	pa									152	Yes 2□I	No 3 ☐ Prot	pably 4 □Unknown
S	s been s should	Completed									24a. Was			ppsy findings available
Re	The lav	mo										rmed?	death?	mpletion of cause of
of Vital	ificet or, p	Ü	25. Was case referred to medical						26 Place	of Death	1 Yes	100	1 🗆 Yes	2 No
>	s cert	0 8	examiner? 1 ☐ Yes 2 📆 No	Hospital:	nt 2□EF	R/Outpatier	nt 3□ DC	Othe	ar.		ne 5∐ Resid		Other (Special	5/1
ion of	nding Physician: The I ath. r: After this certificete he e funeral director, page	-	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da	гу 2	8b. Time of Injury		Bc. Injury Work		2	28d. Describe t			,,
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Aller this certifice completely filled in by the funeral director; p	Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injuding, et	ury - At hom c. (Specify)	e, farm, str	eet, factor	y, office		2	28f. Location (S City or Tox	Street and f vn, State)	lumber or Rura	al Route Number,
	he Hospi in 24 hou he Funer pletely fill	edicai	29a. Certifier 1	ysician: To the best niner: On the basis of and manner sta	examination	edge, deatl n and/or in	vestigation	, in my op	pinion, deat	d place, a	and due to the ed at the time,	cause(s) ar date and pl	id manner as s ace, and due to	tated. o the cause(s)
-	Tot Tot Com	Σ	29b. Signature and little of certifier	4 .	-		290	c. License	number			29d. Date s	igned (Month,	Day, Year)
Ç	SILUA		Dance	telken		m	1	051	441	. 1 .		Mar	65	200h
1	1		30. Name and address of erson who	completed cause of d	eath (Item 2	3a) (T)	rint)				r	, ,,,,		
У.	100	1	Beverly M. Cal	Kins M.D	. 5co	Me	motion	al A	lue.	Cu	mberla	and,	Maryl	2006 and 21502
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				1 = For State Registrar	State of Ma	aryland		rtment			Mental Hy	/giene Reg. No	ZUU	6	167	162
		Physici	an	1. Decedent's Name (First, Middle, Last)							2. Date of D			ear	3. Time of	Death
		/Media	cal		Lee Radi	ford					MAY	112	20	06	11:0	5AM
	4	Examir	ier	4a. Facility Name (If not institution give stre	Pet and number)	5.7		4b. City, 1	own or	Location of De	ath /	4c	County of	Death	λ	
		Funeral		5. Social Security Number 6. Sex	, , ,	(In yrs. la	st birthday)	If Under		If Under 34 H	S. 8. Date of B	irth	17/1/1/19	. Birthold	ace (State or	r Foreian
	Ш	Director		218-32-7261	2 ⊠ F	86	Yrs.	Months	Days	Hours Mi	s. 8. Date of B (Month, D Feb. 2	o,19	20 No	Count	(Carol	lina
		land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10	d. Inside Cit	v l imits
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		death with the Maryland rme 23a or 28e-f show Frints Let notified at	Director	10e. Street and Number				10f. Zip (Code			10g. Cit	izen of Wha	at Count	ry?	
		ath wi		114 Francis Street					2107	78		4	U.S.	Α.		
0		ours after death with the Maryla raf', or iteme 23a or 28e-f shov Exari fret instal by rodiffed at	Funeral	11. Marital Status 12. 1 Never Married 2 Married	Was Decedent E		i. 13. V	Vas Decede Yes, speci	ent of His fy Cubar	spanic Origin? n, Mexican, Pue	Specify Yes or N orto Rican, etc.)	0-	14. Race - Black,	America White, e		
0	036	urs af	þ	3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 N If Yes, Give Year or Dates:	10	1	☐ Yes 2	X No	Specify:			Specify:	Whit	:e	
13	21215-0036		Completed	15. Decedent's Educat (Specify only highest grade c	ion ompleted)		16a. Deced	ent's Usual	Occupa	tion uring most of w	orking.	16b. K	ind of Busin	ess/Indi	ıstrv	
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RADFOR		filed Hygir ther int, I		17. Father's Name (First, Middle, Last)			De	ntal		.stant	ame (First, Middle			.116,	Maryı	and
14	land	d a b	To Be	Walter	L. Sharp	e e					Margare		-			
7	lary			19a. Informant's Name/Relationship (Type,	Print)		19b. Mailin	g Address ((Street a	nd Number or F	Rural Route Numb	per, City o	r Town, Sta	te, Zip (Code)	
14	Z,	1 and 2 Health tem 27 other tre		Ann E. Radford							, Apt. No.	2, W	est Lek	anon	, NH 03	784
7	Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem	noval from State		nce of Dispos metery, crem				Date	20c. Lo	cation - Cit	y or Tow	m, State	
3	Ħ	그 든 모 글		* 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		Pri	ncipio			of Facility	/20/06	Peri	yvil1	e, l	Maryla	nd
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C				23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one	ions that caused	the death.	Do not ente	r the mode	of dying	Maryla , such as cardia	ac or respiratory a	903-(irrest,	1766_		Approximate nterval Betw	
		Physician		Immediate Cause (Final disease or condition	Mu	11 Cal	dial	Clat	Land	tion					Onset and De	eath
		/Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):	()	00 (
.0			er	Sequentially list conditions, b. –	Due to (or as a	conseque	VAY I	1510	4					L	1+a-	<i>/</i>
d		d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1/20	4.	la.	210	1114	trical	Proposition la	104			.000	,
1	0,	sate be executed bysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a	conseque	ence of):	0001	2011	(?	Coll - rail	FV			1 Par	
	8760	cate chys the	dicai	d												
	9 x	Attending Physicien: The law requires that the death certific rideath. rideath. setor: After this certificate has been signed by the attending petor: After this certificate has been signed by the attending py the funeral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23c.	If yes, outcome of	of pregnance	cv									
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	0 [ding Pt h. After tt funeral		27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 2	8b. Time of Injury	280	c. Injury a		28d. Describe			spoony)		
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		To the Hospitei or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physici 2 Medicel Examiner	On the basis of e	examinatio	edge, death n and/or inve	occurred at	the time	, date and plac nion, death occ	e, and due to the urred at the time,	cause(s) date and	and manne	r as state	ed. ne cause(s)	
		To the within 2 To the complet	Me	29b. Signature and title of certifier	and manner stat				License				signed (M			
				00 Call	Mh	MV	7	1	127	975		P1	12/1/6	/	,	
		,		30. Name and address of person who comp	leted cause of dea	ath (Item 2	(Type, P	rint)	Y	101	2 1 1	V ((1,00		/ /	
		Sto	•	31. Date filed (Month, Day, Year)	32 Registrar	o/J	MA	Clan	V.	/W /	7 el 141	1	und	10/	4	
		Sta Registra	_	MAY 1 5 2006	Descer	1	April	W.								

		1 - For State Registrar	State of	Maryland		artment tificate			ınd M		Reg. No.	2006	16763
Physici	a n	1. Decedent's Name (First, Middle, Las	t)							Date of De Month	ath Day	Year	3. Time of Death
/Medic		MAIRLUE	S.		SUL	LIVAN				MAY	12,		5:23A M
Examin	er	4a. Facility Name (If not institution, give	street and numb	ber)		4b. City, T	own, or	Location o	f Death		4c. (County of Death	
		Northampton Man					eder		241140			Freder	
Funeral		5. Social Security Number 6. Se	x ⊐M 25∑1F	. Age (In yrs. la		If Under 1 Months	Days	If Under a	Min.	8. Date of Bir (Month, Da	y, Year)		place (State or Foreign intry)
Director		386-10-7976 Usual Residence of Decedent	71	8'	9 '''					AUG. 2	2,191	6 Mic	higan
and #		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
Many	ō	Maryland Frede	erick	V	Valker	sville	9						1 X Yes 2 □ No
the result	Director	10e. Street and Number				10f. Zip (Code				10g. Citiz	en of What Cou	intry?
3a or		201 Sandstone	Drive				2179	3			Un	ited St	tates
death ms 2	Funerai	11. Marital Status	12. Was Deced	ent Ever in U.S	S. 13. \				gin? (Spe	cify Yes or No Rican, etc.)		4. Race - Ameri	ican Indian,
or he after	Ē	1 ☐ Never Married 2 ☐ Married	Armed Ford	X No	ĺ	1 ☐ Yes 2		Specify:	, ruento	nican, etc.)		Black, White, Specify: W	hite
ours Fire	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	es:			<u> </u>	Openy.				Specily. W	
72 h	Completed	15. Decedent's Ed (Specify only highest gra	ucation de <i>completed)</i>		16a. Deced	dent's Usual kind of work DO NOT use	Occupa done d	tion uring most	of workii	ng	16b. Kin	d of Business/Ir	ndustry
within 10.00.	m d	Elementary/Secondary (0-12)	College (1-4	tor 5+)		tisti					For	lorol Co	vernment
iled y dygie ther t		17. Father's Name (First, Middle, Last)			D L a	LISLI			r's Name	(First, Middle			vernment
of of o	Be		D. 9	ULLIVA	N			MAY			BELL	, , , , , , , , , , , , , , , , , , , ,	
In year of Lies 13, 2000 should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "naturel", or liems 23a or 28a-f show matic event, the Maylcal Examinar roust be motified at	၉	19a. Informant's Name/Relationship (7		70111111		na Address	(Street a					Town, State, Zij	n Code)
d 2 s th an t7 le u			uchter			4 Mud				20			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heath and Marial Hygiens. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f show any njury or other treumatic event, the Marical Examinar must be notified at once.		20a. Method of Disposition	ugitter	20b. Pl	ace of Dispo	sition (Nami	e of			/ Inur		Mary 18 ation - City or T	and 21788 own, State
mit. Pages pertment of portant: if if y njury or c		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		ate	metery, crer			. 1	5/15	12006	The a d	erick,M	1 1
ortan		21. Signature of Funeral Service Licen		Kes	22	. Name and	Addres	s of Facility) St	/2000	Funer	erick,M cal Home	aryland
Page and pag		Parposal	Polo	0100								cick, MI	
Physician /Medical Examiner	niner	23a. Part 1. Forer the disease, or composition in shock of heart failure. List only of lisease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	aDue to (o	ch line.	ence of):	UT C	EN	BBRA	LVA	ASCULA	n A	CCIOSNI BASE	Approximate Interval Between Onset and Death
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Amend 28 c,d,e,f AACO GSR per phy 5/15/06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Diana Lee Sorese 1030 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2ĂF Months Days Hours Director 220-56-0675 55 Dec. KΥ Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show other traumatic event, the Medical Examiner must be notified at MD Severna Park Anne Arundel Director 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 84 Robinson Landing Road 21146 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after ☐ Yes 2 X No Yes, Give 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" . 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Heelth and Mental Hygiene Important: if item 27 is marked other than "n any injury or other traumatic event, the Madione. Elementary/Secondary (0-12) College (1-4or 5+) Federal Employee U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Troy W. Wells Vergie Lanham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard J. Sorese/Husband 84 Robinson Landing Road, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 6, 2006 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 21. Signature of Pageral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cause or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Priysician -d671 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of). Examiner it any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transi certificate be exec Due to (or as a consequence of): the attending physician Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy į in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No 1 ☐ Yes 212 No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Cther: 1. Yes 2 No 4 Nursing Home this 1 Dinpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death winjury occurred Fell in parking Certification: After 3:30 M 1 Natural 5 Pending death. investigation 102/2006 2 Accident 141/5 after death 6 Could not be determined 28e. Place of 'njury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Fr. L. Meny, National 4 Homicide within 24 hours a To the Funeral D Office parking lot Med . Bus part 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier one) 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) ()31. Date filed (Mo Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene? For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY Physician WTT.T.TAM STAFFORD 2006 9:15 A M Μ. 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2□ F 91 078-01-0642 Yrs. April 13 1915 New York Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a, State in then "neturel", or itema 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Gaithersburg Mđ. Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20886 United States 20204 Maple Leaf Court by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Budget Analyst U. S. Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental ant: If Item 27 is marked o Stafford, Sr. Viola Waterman George C. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gail A. Stafford / Daughter 20517 Sterncroft Court, Gaithersburg, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State tant: Resthaven Memorial 5/13/06 Frederick, Md. 4 □ Donation 5 □ Other (Specify) permit.
Departn
Imports
any Inju 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DAYS CANDIDA ALBICANS URINARY TRACT INFECTION /Medical Due to (or as a consequence of): Examiner SEPSIS WITH SEPTIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner nding physiclen and use as the burial-transit The law requires that the death certificate be executed BILATERAL PNEUMONIA resulting in death) Last Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No atten for us 3 Ectopic pregnancy Month Day Year signed by the at a be detached to 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ٦ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2□ No 1 ☐ Yes 2 🗷 No 1 Yes of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this Alter thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; Division 1 Natural 5 Pending To the Hospital or Attending
within 24 hours after death.
To the Funeral Director: Alte
completely filled in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 298 Cartifier 1 🔀 Certifying Physician: To the best of my knowledge, death becurred at the time date and place, and due to the rause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Chow a MAY 10, 2006 D0058965 6+1 30. Name and address of person who completed cause of death (It a 3 a) (Type, Print) 11119 ROCKVILLE PIKE, SUITE #100, ROCKVILLE, MD. 20852 SAIMA KHAWAJA, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

MAY 1 2 2006



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State Registrar

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Projection (Medical Examinor conditions southwith the conditions southw				23a. Part1. Enter the disease, or comp	plications that cause one cause on each l	d the death. Do n	ot enter the mo	de of dying,	, such as cardiac	or respiratory arre	est,				
Due to (or as a consequence of):		Physician	. 10	Immediate Cause (Final	MARI	100 at	ain	AH	witi			Onset and Death			
Sequentially list conditions: Sequentially list conditions as a consequence of	7	/Medical			Due to (or as	a consequence		1.10	/ / / /			00000			
Due to (or as a consequence of): The past 2		Examiner		Sequentially list conditions	h										
Due to (or as a consequence of): The control of the control of		T =	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):								
The state of the s		cutec nd rans	ami	trial trittated events	c										
See a graph of the complete of	o,	e exe ien a urial-1		resulting in death) Last	Due to (or as	a consequence o	of):								
243. Was an autopsy findings available prince to completion of cause of death? 244. Was an autopsy performed; autopsy perfor	376	ate br nysic he bi	lca		d										
243. Was an autopsy findings available prince to completion of cause of death? 244. Was an autopsy performed; autopsy perfor	39	ntifica ng pl	Ved	IE EEMAI E:											
243. Was an autopsy findings available prince to completion of cause of death? 244. Was an autopsy performed; autopsy perfor	õ	th ce tendi	an/I	23b. Was decedent pregnant			3 ⊟Ectopic p	regnancy				•			
243. Was an autopsy findings available prince to completion of cause of death? 244. Was an autopsy performed; autopsy perfor		e dea ha at	SICI	1 ☐ Yes 2 ☐ No		t time of death	5 Other (s	pecify)		-	Width	Day real			
243. Was an autopsy findings available prince to completion of cause of death? 244. Was an autopsy performed; autopsy perfor	P.0	at the	Phy						: B : 1	ana Didast			_		
243. Was an autopsy findings available prince to completion of cause of death? 244. Was an autopsy performed; autopsy perfor		igner bed	þ	Paril Other significant conditions c	ontributing to death t	out not resulting in	tne unaeriying	cause giver	ı in Part I.						
243. Was an autopsy findings available prince to completion of cause of death? 244. Was an autopsy performed; autopsy perfor	oro	een s	ted	DIFFICE (C)		0.1			2		35 Z 🗆 NO 3 (Probably	<i>r</i> tt		
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier (Day, Year) 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) Robert E. Rapp, Jr., M.D., 912 Seton Drive, Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32. Signature	/ita	cian:	0					1 -		h Check only on	e)				
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier (Day, Year) 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) Robert E. Rapp, Jr., M.D., 912 Seton Drive, Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32. Signature	<u>~</u>	hysi his c	၉	1 ☐ Yes 2√ No	1 🔲 inpati			UA	4 Nursing no			(Specify)			
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D54756 May 15, 2006 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) Robert E. Rapp, Jr., M.D., 912 Seton Drive, Cumberland, MD 21502 State 31. Date filed (Month, Day, Year) 32. Pigistrar's Signature		urs a		00 0 vii v	1										
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							book	,							

06-03236

Dennis L Shanholtz

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar	Cer	tificate of D	eath		Reg	. No.	10 10/0
Physician	1/	 Decedent's Name (First, Middle,Las 					Date of Death Month	Day Year	3. Time of Death
ledical Examin		Dennis 4a. Facility Name (if not institution, giv	Leland		Shanhol	Ltz Location of Death	May 13, 20	4c. County of De	1403 hrs
		Memorial Hospital	e street and number)	1	city, fown, or Cumberland		1	Allegany	201
Funeral	7	5. Social Security Number 6. S	ex 7. Age (In yrs. la	ist birthday)	f Under 1 Yea	If Under 24Hrs	8. Date of Birth		Birthplace (State or
Director			Mg 2 F 4.8	Yrs.	Months Day	s Hours Min	11/06/	1957 For	country) Maryland
ru k		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits
ihow :	اي	WV Miner	al	Ridgel	ev				1 Yes 2 X No
Aaryland 28a-f show any 1 at -nce.	Director	10e. Street and Number			Of. Zip Code		109	g. Citizen of What Co	ountry?
th the Maryland 23a or 28a-f sho notified at once		Route 1 Bo	x 253		267	753		USA	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she marite event, the Medical Examinar must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Married	12. Was Decedent Ever in U.S Armed Forces?			spanic Origin? (Sp n, Mexican, Puerto		14. Race - Am White, etc	erican Indian, Black,
ifter d	면 된	3 Widowed 4 Divorced	1 Yes 2 No	1 Ye	es 2 X No	specify.		Specify:	White
nours a		15. Decedent's Education (Specify o		16a Decedent's	Jsual Dccupat	tion (Give kind of v	work done	16b. Kind of Busines	s/Industry
5-0036 iled within 72 h Hygiene I other than "r the Medical E	Completed	Elementary/Secondary (0-12) 1 2	College (1-4 or 5+)		nductor			Railr	a a d
21215-0036 Muld be filed within 7 Mental Hygiene marked other than c event, the Medica	탉	17. Father's Name (First, Middle, Last)	-	100000		e (First, Middle, Ma		
215 be file ntal H rked	a	James	Sewell	Shanh		Cora		ginia	Morris
D 21 should and Me is ma	2	19a Informant's Name/Relationship (U.	,			er, City or Town, Sta	
- v = e =	1	Vickie Shanholtz 20a Method of Disposition		Route				est Virgingon - City	
ges la tof H		1 X Burial 2 Cremation 3	Removal from State	rematory or other	place)			,	
Baltimore, permit. Pages I an Department of Hea Important: If iter njury or other tr	ŀ	4 Donation 5 Other Specify 21. Signature of Funeral Service Lices		ndale Ce	metery e and Address	s of Facility A A	/16/2006	Flintst	one, MD. L Home, P.A.
Dep Dep Initial		Labort C. C.	Celanu					rland, MD	21502
Physician	1	23a. Part I. Enter the disease, or com failure. List only one cause on e							Approximate Interval Between Onset and
Immediate Cause (Final disease a Acute Coronary Artery Thrombosis									Death
	- 1	or condition resulting in death)	Due to (or as a consequence of	·):					
	je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	·):					
	E	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	i):					
ecuted and transit		d							
760, cate be execut physician and he burial - tra	Medical	UNPENDED	AMENDED	_				2-84-56	
8760, tificate be ng physic as the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr	ancy Petal	death 3	Ectopic pregna	ancy	23d. Date of deliv Month	ery Day Year
Box 687; death certiff	sician	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at time of de	oth	(Specify)				
that the de red by the detached for	ᇍ	Part II. Other significant conditions	9 Onknown	esultina in the und	erlving cause o	given in Part I.	23e, Did tob	acco use contribute	to the cause of death?
, P.C res that signed b	2	Hypertensive Atheroscle	-	-			1 Yes	2 No 3 P	robably 4 🗸 Unknown
ords, w require	eted						24a Was ar		autopsy findings available
e law e has l	Completed						autops perform 1 ✓ Yes 2	ned? death	
Vital Recysician: The libic certificate lidirector, page	္စ္မို	25. Was case referred to medical			26.Place	e of Death (Check		No1 ✓	Yes 2 No
Vita hysicia this ce	삥	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA	Other Nursir	ng Home 5 R	esidence 6 Ott	ner:
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is after death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Ë	27. Manner of Death 1 Natural 5 Panding	28a. Date of Injury (Month, Day, Year)	28b. Time of Injur	· -	iry at Work?	28d. Describe ho	w injury occurred	
Sior Attend r death ector: by the	läti	2 Accident 5 Pending Investigat				Yes 2 No	005 1		
Divis	Certification:	3 Suicide 6 Could not determine		ome, farm, street, f	actory, office t	building, etc.	or Town, Sta		Rural Route Number, City
Hospit 4 hour Funera		4 Homicide 29a Certifier 1 Certifying Physic	sian: To the best of my knowledge	ge, death occurred	at the time, d	ate and place, and	due to the cause	(s) and manner as s	arted.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	Official of the	r:On the basis of examination at and manner stated						
FSF5	ž	29b. Signature and title of certifier		7-4-1	29c. Licens		Ī	29d Date signed (f	Month, Day, Year)
		Chel	Hall	DU	O.C.	M.E.		May 14, 2006	
92		30. Name and address of person who Carpl Allan, MD Assist.		^{23a)} 111 Penn Str	eet, Baltim	nore, MD 2120)1		
Sta	ate	31. Date filed (Month, Day Year)	32. Regionar's Signatu	ire					
Regist		MAY 1 5	2006 Maria	H No	WE !				

			1 - For State Registrar		aryland / Dep <i>Ce</i>		nt of H		F	eg. No.	006	1677 ()
	Physici	an	Decedent's Name (First, Middle, Last	(1)					2. Date of Dea Month	th Day	Yea	r	
	/Media		Edna	Odess	а		ver		MAY 97		2006	15:10	М
	Examir	er	4a. Facility Name (If not institution, give	street and number)		4b. City	y, Town, or	Location of Dea	ith		County of De	eath	
			MEMORIAL HOSPITAL				BERLA				LEGANY		
	Funeral		5. Social Security Number 6. S		e (In yrs. last birthday)	Months	er 1 Year Days	If Under 24 Hr Hours Mir	(Month, Day			irthplace (State or Foreig Country)	ign
	Director		217-10-5250	2 m 5 dy.	9.2 Yrs.	<u> </u>			05/02/	1914	Wes	st Virginia	
	P		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation						10d. Inside City Limit	its
	eho	7	MD Alleg	anv	7,		aptor	7 D				1 ☐ Yes 2 🕅 N	
	8a-f	ecto		ally				A 11		10- Oil		22	
	vith t	ā	10e. Street and Number			10t. Z	ip Code	21502		rog. Citiz	zen of What	Country?	
	ath v	rai	12610 Valley					21502			USA		
	er de	une	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	If Yes, sp	edent of Hi ecify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or No- irto Rican, etc.)		Black, W	nerican Indian, hite, etc.	
36	or la	Ϋ́F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N	10	1 🗆 Yes	2X) No	Specify:			Specify:	White	
21215-0036	72 hours after death with the Maryland neturel', or items 23s or 28s-f ehow dissi Ezami et must be indified at	Completed by Funeral Director		Year or Dates:	162 Door	dont's He	ual Occupa	tion	F	16h Kir	nd of Busines		
7	n 72	lete	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	kind of w	vork done d use retired	lurina most of w	orking	TOD. KII	id of ousing:	samuustry	
7	then then	Ē	Elementary/Secondary (0-12)	College (1-4or 5	+)	Coo		,		R	estaur	ant	
2	Hygie Ther nt,		17. Father's Name (First, Middle, Last)				, K	18. Mother's N	ame (First, Middle,			ane	
an S	d le b	Be			Sherma			Emma	arro (r mar, maaro,			Woerner	
<u>\$</u>	1 Mer	ဥ		Joseph			(011		S (S 4 /)	. 0:4	T C4-1-		
Maryland	s 1 end 2 should be filed within 72 hours after death with the Marylar if Health and Mentel Hygiene. Item 27 is marked other then "neturel", or items 23s or 28s-f ehow other treumatic event, the Medical Examinar interior builded at		19a. Informant's Name/Relationship (•	**	-			Rural Route Numbe				
	end leafth m 27		Marisa Wright / g	randdaught			-		nue, Cres				
Baltimore,	of H of H if ite		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, cre					20c. Lo	cation - City	or Town, State	
<u>Ē</u>	Pag ment: ant: ury c		4 ☐ Donation 5 ☐ Other (Specif		Cumberla						berlar	•	
at	permit. Pages Department of the Important: If its any injury or of once.	1	21. Signature of Funeral Service Licer	ISOO /								I Home, P.A	Α.
8	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		Trhit C.	Cielan	-	+04 1	ecatu	ir Stree	t, Cumber	rlan	d, MD	21502	
	Physician /Medical Examiner	16	23a. Parl1. Enter the disease, or com shock, or heart failure. List only firmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	aDue to Nr as	a consequence of:	1	I TO	SAS)	9 51,		Approximate Intervat Between Onset and Death	5
68760,	cate be executed physicien and the burial-transit	dical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):								
O. Box	at the deeth certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetaf death 3	⊒Ectopic ⊒ Other (:	pregnancy specify)			2	3d. Date of o	lelivery Day Year	
rds, P	w requires thet the been signed by th should be detache	ed by P	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	inderlying	cause give	on in Part I.	23e. Did to			to the cause of death? Probably 4 DUnknow	₩Π
of Vital Records,	The law ete hes b page 2 st	Completed by							24a. Was a autop: perfor 1 Yes	SV	prior t death	autopsy findings availab o completion of cause of ? es 2 \sum No	ole if
/its	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?				Tai		eath (Check only or	10)			
<u></u>	Physician: r this certific ral director,	ဥ	1 ☐ Yes 2 No		nt 2 ☐ ER/Outpatie			4 Nulshiy	Home 5 ☐ Resid	ence 6	Other (S	oecify)	
2	ter field	i.	27. Manner of Death 1	28a. Date of Inju (Month, Da	ry 28b. Time o Y Ye <i>ar)</i> Injury	of	28c. Injury Work	at ?	28d. Describe h	ow infun	occurred		
.ig	Attending r deeth. ector: Atter	atic	2 ☐ Accident investigation	1		М	1 🗆 ነ	res 2 □No					
Division	To the Hospital or Attendi within 24 hours after deeth. To the Funeral Director: A completely filled in by the fu	edical Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, facto	ory, office		28f. Location (S City or Tow			Rural Route Number,	
	he Hospi in 24 hou he Funer pietely fill	edicai	27a Gentitier 1⊠ Certifying Pt (Check only one) 2 Medical Exar	niner: On the basis of and manner sta	examination and/or inted.	nvestigation	d at the fin on, in my op	e, data and plai pinion, death oc	ts, and dua to the o curred at the time, o	ausu(s) late and	and manner place, and d	ds stated, ue to the cause(s)	
	To To t	Σ	29b. Signature and title of certifier	\sim	BINO	2	9c. License	number	2	9d. Date	e signed (Mo	nth, Day, Year)	
	4		169	er cley	(10	`	D.3	1875		~	1AV 10	3/200	
			30. Name and address of person who	mipleted cause of d	eath (It m 23a) (Type,	Print)				-	1	7	
	n RS		WELIK, ROBERT A.,	M.D., 902	SETON DRI	VE,	SUITE	308, C	UMBERLANI	, MI	2150	2	
3	Sta Regist	ate	31. Date filed (Month, Day, Year)		ar's Signature	bert	1						

Merritt Andrew Shenk

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 16771

			1- For State Certificate of Death Reg. No.											UIL)		
	Physicia	ın/	 Decedent's Name (First, Midd 								Date of Death Month Day Year 0235 hrs						
Vied	cal Exami			lerritt .		Shen		O': T				May 13	3, 2006	4c. County c	f De eth	0235 hrs	
			4a. Facility Name (if not institution 1706 Belvidere Road	on, give street an	d number)	4b. City, Town, or Location of Death Port Deposit							Cecil				
	Funeral	╗	5. Social Security Number	6. Sex	7. Age (In	rs. last bi	rthday)	If Under	_	If Under Hours	24Hrs.		,			hplace (State o	
	Director		213-28-3310	1XM 2]F 7	4	Yrs.	Months	Days	nouis	IVIIII.	May	23,	1931		untry)	
			Usual Residence of Decedent		140-	Oit Terr		_								10d Inside Cit	y Limite
	w any	- 1	10a. State 10b. County		100.	City, Tow	n or Locatio									1 Yes 2	-
	Maryland 28a-f show d at once.	흐	Maryland 10e, Street and Number	Cecil				Port	Dep	osit			100.0	Citizen of Wh	at Cour]	
	e refi	Director	408 Linton Ru	n Road				TOI. ZIP	219	904			log. c		S.A.	-	
	with the 18 23a ne noti		11. Marital Status		Decedent Ever	in U.S.						cify Yes o				can Indian, Blad	ck,
	r iten	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.														
	after	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify: Specify: Specify: Specify: Or Dates: 15 Decedant's Education (Specify: Or Dates: 16 Decedant's Listed Occupation (Give kind of work done. 116) Kind of Ru												White			
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	imore, MD 2121 Pages I and 2 should be fil ment of Health and Mental F tant: If item 27 is marked or other traumatic event,	ည	19a. Informant's Name/Relations			200	_		,					City or Town			004
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	altimore, mit. Pages I ar partment of Hee portant: If ite	- [4 Donation 5 Other S			R.A. 1	Ferris				05/3	15/06	We	st Ches	ter,	Pennsylv	ania
21. Signature of Funeral Service Licensee Lee A. Patterson & Son Funer												P.A.					
	Physician	\dashv	23a. Part I. Enter the disease, or	r complications th	nat caused the c	leath. Do	Per not enter the	cryvi e mode o	11e, f dying, si	Mar uch as ca	ylar ardiac or i	respirator	<u>1903</u> y arrest, s	_0766 shock, or hea	art	Approximate	
	/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a, Hypertensive Atherosclerotic Cardiovascular Disease Death														
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R	uted nd ransit		events resulting in death) Last	Due to (or	as a conseque	nce of):											A
A.	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	n/Medical	UNPENDED	AMEND	ED	_											
	8760, rificate b ng physic as the bu	/We	IF FEMALE. 23b. Was decedent pregnant in t	U	yes, outcome of	pregnanc	-			7				23d. Date of			
	68 certifi nding Ise as	ian	past 12 months?	'	live birth Pregnant at time	of death		al death er (S <i>pec</i>	3	Letopic	pregnan	су		Month	-	Day Ye	ear
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	ivision or Attend after death. Director:	atic		nding estigation								201 1	(0)			(5 t N1	0.1
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	Ospita lospita l hours uneral ly fille	ပ္ပ	29a. Certifier	Physician: To th		wiedae (teath accurr	ed at the	time date	e and nia	ce and c	fue to the	cause(s)	and manner	as star	ted	
	To the Ho within 24 To the Fe completel	Medical	(Check only one) 2 ✓ Medical Ex	aminer: On the b	asis of examina	tion and/o	r investigati	on, in my	opinion,	death occ	curred at	the time,	date and	place, and d	ue to th	e cause(s)	
	To To	Me	29b. Signature and title of certif		iner stated.			29c	License	number			29	ld. Date signi	ed (Mo	nth, Day, Year)	
			totulle	N). [/A	- Hall) le			O.C.M	1.E.			М	lay 13, 20	06		
		ļ ķ	30. Name and address of perso	n who completed	cause of death	(Item 23a											
	5	9 8	Patricia Aronica-Polla	ak MD. As	sistant Med		miner	111 Pe	enn Stre	eet, Ba	Itimore	, MD 2	1201				- 4
				5 2006 3	32. Segistrar's S		M. A										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 per dvr 8855 5-25-06 vt. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2:09 AM 2 Date of Death cedent's Name (First, Middle, Last) Year **Physician** ICE 2006 a /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number, Examiner Saltimore Maryland 0 Center University If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth Month, Day, Une S) Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 8 Months Hours Min 1 □ M 2 😿 F -46 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland own or Location 10a, State 10b. County 10c. City 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director MD Howard lumbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Chain 238 633 21045 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: itema Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 💥 No Baltimore, Maryland 21215-0036 0 Specify: þ 3 ☐ Widowed 4 ☐ Divorced american naturai Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1,4or 5+) ministrative rederal Hssistan Covernmen other it of Health and Mental Hyg if item 27 is marked other or other traumatic event, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lossie Pages 1 and 2 should be oope 5 500 - 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) 6332 and Chain olumbia MD ederick (Name of Date 20b. Place of Disposition 20a. Method of Disposition 20c. Location - City or Town, State cemetery crematory other 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 9,2006 permit. Page Department of Important: if any injury or once. May Kiverdale KL Reni. tiverdale James Lincoln Bonne 21. Signature of Funeral Service Licensee 22. Name and Address of Facility He + ASSOC Funeral Home 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple Myeloma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Failure Renal if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 Completed by Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea use 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? jo Month Year Day 4☐Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed: certificate 1 Yes 2 No 1 Yes 2 No Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No ٩ 1XInpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident the Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by determined 4 Homicide within 24 hours after To the Funeral Dire To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, S. Greene labatabai 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene 16773 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 05-07-2008 A M 4:35 Towers James Irving /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St.Mary's Leonardtown 18791 McKay's Beach Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 9-19-1910 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**☆**M 2□F Yrs. 95 Director 579-03-7809 Hawthorne, N.J. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mentel Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at 1 AYes 2 No Directo Maryland St.Mary's Leonardtown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20650 18791 McKay's Beach Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 Specify: White Be Completed by 3- Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 08th College (1-4or 5+) Plumber Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara Walker Ford Towers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1068 Red Maple Ct. Davidsonville, Md. 21035 Anne R. Shaver/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Tremation 3 ☐ Removal from State Riverdale, Md. Riverdale Park Crem. ' 4 ☐ Donation 5 ☐ Other (Specify) 5-11-06 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20746

Cedar Hill FH Inc. 4111 Penn. Ave. Suitland, Md. May Hedgman Mo13 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions.
If y leading to in reclaid cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) as ed by the attending property detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Nikhown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2021 page 1 Yes 2 10 this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ome 5 Residence 6 □Other (Specify)
28d. Des ribe how injury occurred 1 ☐ Yes 2 🐧 № 2 27. Manner of D at 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death unaral Director; the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a Hospital 29a. Certifier 🗡 🚅 Titrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D19917 06 30. Name and address of riss who completed this death (Item 23a) (Type, Print) 20619 California, Maryland 2050 Wildwood Center MD James Boyd, 31. Date filed (Month, Day, Year) MAY 1 6 2006 Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 6

1- State Amend#5.PerFam.PCC 5-19-06 Cr
Registrar Amend #1.PerPhys.PCC 5-16-06cr

Certificate of Death

Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JACQUELYN D. TURNER Physician Jacqueline 10:40A May 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospital RANDHIISTOREN Baltimore Northwest If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/18/52 7. Age (In yrs. last birthday) 53 vrs 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Director Wash.,D.C. Usual Residence of Decedent with the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "neture!, or items 23a or 28a-f shov the Medical Examinar must be notified at 1 Yes 2 □ No Md. Prince George's Directo Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 322 Gibson Drive 20745 U.S.A. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1[™] Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes Ž No Specify: Black Specify δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Personnel Specialist U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Turner Madeline V. Nelson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janece L. Turner/Daughter 322 Gibson Dr., Oxon Hill, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: if ite
eny injury or ott 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/20/06 Harmony Mem. Park Landover, Md. 22. Name and Address of Facility & Sons Co. Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee any 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** A therosclerotic Christianssular Disease /Medical Examiner Hypertension
Due to (or at a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2/2 No 1 ☐ Yes 2 ☐ No director 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this tor: After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

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State Registrar 31. Date filed (Month, Day, Year)
MAY 1 6 2006

Jenniferz Yorke DO

Nov Knaxs + Hespital
32. Registrar's Signature

louse

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

40055644

11 2006

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of V	Physician: rthis certific ral director,	မ	1 ☐ Yes 2X No		☐ ER/Outpatien			lursing Home	5 🗌 Resider	nce 6 🗆 O	ther (Specif	y)		
ion o	ding h. After fune	atlon:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury		Injury at Work? 1 ☐ Yes 2 ☐		. Describe hov	w injury occ	urred			
Division	9 # # =	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	eet, factory, off	lice	281.	Location (Stre City or Town,		mber or Rura	i Route Number,		
	F F F	edical (29a. Certifier F Certifying Ph (Check only one) 2 Medical Exan	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the	ne time, date a ny opinion, de	ind place, and ath occurred	due to the car at the time, da	use(s) and r te and place	manner as s e, and due to	tated. o the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and the of certifier	011		29c. Lic	cense number		29	d. Date sign	ned (Month,	Day, Year)		
			1/am	ffece		00	532	-35		5/10	106			

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person to completed cause of death (Item 23a) (Type, Print)

Darryl A. Hill, M.D. 13635 Baltimore Avenue, Laurel, MD

ORIGINAL

20707

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2006 Month Physician May There'se Marie 20, Thompson 6:00 A.MM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 317 Robin Hood Road Havre de Grace Harford 8. Date of Birth (Month, Day, Year) Mar. 1, 1930 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Birthplace (State or Foreign
 Country) 1 ☐ M 2 🔀 F 470-30-4574 76 Director Minnesota Usual Residence of Decedent with the Maryland 10a, State 27 is marked other then "naturel", or Items 23e or 28e-f show treumatic event, the Medical Examinations to notified at 10c. City, Town or Location 10d. Inside City Limits MD Harford Director Havre de Grace 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 317 Robin Hood Road 21078 U.S.A. Funeral death 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene. nt: If item 271s marked other then "naturel", or Ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: White 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pierre Emard ٥ Ida May Boucher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Thompson, Jr. 317 Robin Hood Rd. Havre de Grace, MD 21078 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5/25/06 1 Burial 2 Cremation 3 Removal from State injury or permit. Page Department importent: If importent: If any injury or any injury or any ence. St. Paul's Lutheran Cem. Aberdeen, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Tarring-Cargo Funeral Aberdeen, Maryland 2 l Home, P.A. 21001-3399 Wen How 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Vanced 10 avs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undérlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine H requires that the death certificate be executed burial-transit and Due to (or as a consequence of): the attending physician hed for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by t d be detach Part If. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown tilled in by the funeral director, page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed 2 No 1 Yes Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 8 Hospitel or Attending Pl 24 hours atter death. 9 Funerel Director; Atter ti Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 Prifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V-e lanue 6 31. Date filed (Month, Pax Year) 2006 32. Registrar's Signature State Registrar

Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month		3. Time of Deat		
/Media	cal	Domenic Vadala		I			May	10 20	06 5:15 F		
Examir	er	4a. Facility Name (If not institution, give 490 Hopewell Road	street and number)			r Location of Deat	h	4c. County of			
uneral			x 7. Age (In yrs	s. last birthday)	Rising If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Bin (Month, Da	th Cecil	9. Birthplace (State or Fore		
rector		127-24-1291 Usual Residence of Decedent	3 M 2□F	82 Yrs.	Months Days	Hours Min.	Februar	y 22, 19	23 Italy		
show	_	10a. State 10b. County	10e. C	City, Town or Loc	cation				10d. Inside City Lin		
28a-f	Funeral Director	MD Cecil 10e. Street and Number		Rising	Sun 10f. Zip Code			10g Citizen of Mile	1 Tes 3		
3a or	Ö	490 Hopewell Road			21911			10g. Citizen of Wh	lat Country?		
ems 2	nera	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. V		lispanic Origin? (S an, Mexican, Puert	pecify Yes or No	- 14. Race -	- American Indian,		
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Once.	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give		Yes 212 No	Specify:	o Rican, etc.)	Specify:	White, etc.		
atural	edk	15. Decedent's Edu		16a, Deced	ent's Usual Occup	ation		16h Kind of Busi	b. Kind of Business/Industry		
Med a	Completed	(Specify only highest grad Elementary/Secondary (0-12)		(Give I	rind of work done of NOT use retired	during most of wor	rking	100.11110.01.000	nosa maasiy		
t a	Con		4	Mus	hroom Gr	ower		Agricu	lture		
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s marked of umatic eve	2	Pietro Vadala 19a. Informant's Name/Relationship (T)	una Printì	10h Mailin	Addrson /Street		ica Rand		7.0.11		
27 is 1 trau		Pietro Vadala/son	pe, riin)	1		low Lane,		er, City or Town, St	ate, Zip Code) 21911		
Item 27 other tra		20a. Method of Disposition	20b.		ition (Name of atory or other place		Date	20c. Location - Ci			
int: If Ite		1 Surial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	terrioval north State		v Cemete	I	16-2006	Risin	Sun MD		
Important: any injury o		21. Signature of Funeral Service Licens							Home, P.A.		
트등등		23a. Parvi. Enter the disease, or compl shock, or heart failure. List only of	lood	re 1	11 S. Que	zen ST.,	Rising.	Sun, MD	21911		
hysician and the burial-transit transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jisewe of Mary that initiated events resulting in death) Last	Due to (or as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consec	equence of):	old L	my Can	ncer				
by the attending pached for use as	Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregr 1	taldéath 3∏í death 5∏	Ectopic pregnancy Other (specify)			23d. Date of Month	,		
been signed should be det	by	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the un	derlying cause give	en in Part I.			ute to the cause of death? ☐ Probably 4 ☐Unkno		
ate has page 2	Completed						24a. Was a autop perfor	sy prio med? dea	re autopsy findings availal or to completion of cause of th? Yes 2 No		
certificate rector, pag	Be	25. Was case referred to medical examiner?	fospital:		Otho		th (Check anly of				
this al di	n: To	27. Manna of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA Othe	4 Nursing A		lence 6 Other of ow injury occurred			
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I Director: ad in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Spec	home, farm, stree	et, factory, office		28f. Location (S City or Tow	itreet and Number on, State)	or Rural Route Number,		
To the Funeral I	edicai (29a. Certifier 1 Certifying Physical Certifying Physical Certifying Physical Exemination (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, death nation and/or inve	occurred at the timestigation, in my op	ie, date and place, pinion, death occur	and due to the c red at the time, c	cause(s) and manne date and place, and	er as stated. I due to the cause(s)		
To the complet	M	29b. Signature and title of certifier	1 0		29c. License	number	2	29d. Date signed (A	Month, Day, Year)		
		V// 190810	J		D33	5653		5/15/0	6 —		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** VARGO 2006 1509 MAY STEPHEN JOSEPH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WORCESTER OCEAN PINES 57 DRAWBRIDGE ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year) 1 XM 2□ F Months Yrs. 1945 PENNSYLVANIA SEPT. 16, **Director** 184-36-3102 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 X Yes 2 □ No WORCESTER OCEAN PINES MARYLAND Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23a or 21811 57 DRAWBRIDGE ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced 'natural' Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) CORRECTIONAL OFFICER MARYLAND STATE 4 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oths any injury or other treumatic event, ODGs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be V. GOLOBIC **VARGO** JOSEPHINE STEPHEN Τ. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 57 DRAWBRIDGE ROAD, OCEAN PINES, MARYLAND 21811 STEPHEN G. DRESSMAN/FRIEND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)
21. Signature of Jun and Service Licensee DELMAR, DELAWARE CREMATORY OF DELMARVA 5/10/06 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part. Ther the disease, or complications that caused the dearn. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiomyopithi ears Pnysician /Medical Due to (or as a consequence of): **Examiner** Alcoholi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2000 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the hours after deat 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 T Homicide within 24 hours a To the Funeral completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title o AGH, Berlin, MD. 21811 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Etherton mo 'e 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 1 2006 Registrar

Please Type or Print in Black Indelible Ink **Burtus Oliver Wilson** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day May 7, 2006 **Medical Examiner** Burtus Oliver 1647 hrs 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Dec. 30, 1935 Director 217-30-9795 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hagerstown 28a-f show Md. Washington Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Count 19920 Thorngrove 21742 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 Yes Specify: BLACK If Yes, Give Yea Divorced 1 Yes 2 No specify: ð 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 6000 W. N COUNSELOR Industrie's 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be GEORGE CUZABETH QUINN ury or other traumatic event, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thorngrove Court Hagerstown Md 21742 Wilson vonne 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) 2 Cremation 3 Burial Removal from State Donation 5 Other Specify 22: Name and Address of Pacility PUNTRAL HOWE Signature of Funeral Service Licenses ARY L POLYNS PUN O WIST SOUTH ST Md. oller 2 a. Part I. 🗐 ter the dis 🛦 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure List only on cause on each line. Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit **DIVISION OF VITAL RECORDS, P.O. Box 68760,**To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical / the attending physician a UNPENDED AMENDED IE FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 V No 3 Probably 4 Unknown Completed been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? certificate ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other₄ this Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes No 28a. Date of Injury (Month, Day Year) May 7, 2006 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred Certification: Deceased driver of vehicle in collision with 1 Natural 1526 hrs Director: 1 Yes 2 ✔ No Pending another vehicle 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Route 40 @ Crysta Falls Drive, Hagerstown, MD determined To the Funeral (Specify) Local Street Homicid 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 8, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Susan Hogan MD. 111 Penn Street, Baltimore, MD 21201

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D2006 Year **Physician** May Mildred Heights Wilkerson 11, 2:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Brandywine

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day,
Sept. 5, Prince George's 16220 Wilkerson Place 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1921 215-36-7382 84 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or frama 23a or 28a-f show tre Medical Examiner must be nutified at 1 ☐ Yes 2 No Directo Maryland Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16220 Wilkerson Place 20613 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X☐ No Specify: Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Food Service Co. Board of Education Injury or other traumatic avant, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked other any lijury or other traumatic avent, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman Henry DeMarr Ida Mae Thompson 19a. Informant's Name/Relationship (Type, Print) M00053 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5035 Clear Valley Place, Brandywine, MD 20613 Elizabeth A. Coulby - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Eps. Cem. May 16, 2006 Aquasco, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License 3035 Old Washington Road fact M.1 Huntt Funeral Home POB 156, Waldorf, MD 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed detached for use as the burial-transi Due to (or as a consequence of): attending physicien Division of Vital Records, P.O. Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 🗆 No To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral (1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Laddress of person who completed cause of death (Item 23a) (Type, Print) ZAFAR A. ANSA RI, ND 31. Date filed (Month, Day, Year) State MAY 1 2 2006 Registrar

			For State Registrar	State	of Maryla		artment of <i>tificate o</i>		i Mental Hy	giene Reg. No.	06	16781		
	S. Division		1. Decedent's Name (First, Middle, Li	ist)					2. Date of De Month	ath Day	Year	3. Time of Death		
П	Physici /Medic		Donald			Winch	ester, S	Sr.	May	11, 200		11:44 PM		
	Examin		4a. Facility Name (If not institution, gi	re street and n	umber)		4b. City, Town	, or Location of De	ath	4c. Coun	ty of Death			
			301 Columbia					mberland		A:	llegar			
	Funeral			Sex 112∏ M 2 □ F		. last birthday)	If Under 1 Year Months Day			th ly, Year)	9. Birthp Cour	place (State or Foreign		
	Director		069-28-9017	INCIN SCIE	70	Yrs.			12/01/			York		
	D		Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or Lo	cation				1	I Od. Inside City Limits		
	anyla aho	٦.	Tou. State		100.0	ky, romi or Lo	oution.					1 🖾 Yes 2 🗆 No		
	Me M	Director	MD Alleg	any		C	umberla			10- 04	140 - 1 0 - 1			
	with t	D.	10e. Street and Number				10f. Zip Code			10g. Citizen of	what Cour	itry ?		
	a 23	rai	301 Columb			10 10	Man Danadania	21502	(Casata Vas as Na	USA	ace - Americ	an Indian		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If Itam 27 is marked other than "natural", or Itama 23a or 28a-f ahow any figury or other traumatic avent. I're Medical Examinar must be notified at angle.	by Funeral	11. Maritat Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed F	2 No		f Yes, specify Ci	uban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		ack, White,	etc.		
21215-003	hou	ed	15. Decedent's E			16a. Dece	dent's Usual Occ	supation		16b. Kind of		ite _{dustry}		
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7	the the	E	Elementary/Secondary (0-12)	Coltege	(1-4or 5+)	Ever	cise Ri	der		Race	Tracl	k		
9	Hyg Than		17. Father's Name (First, Middle, Las	t)		1 DAC	CISC IN		lame (First, Middle			X		
Maryland	d be	To Be	Gerald		F	rohn		Mary	(Olive	Wii	nchester		
\leq	Shoul Mari	F-	19a. Informant's Name/Relationship	(Type, Print)			a Address (Stre	J	Rural Route Numb					
∑	trau		Jeanette Winches		ife				, Cumberl					
ō,	Hear Hear		20a. Method of Disposition	CCI / W		Place of Dispo	sition (Name of		Date	20c. Location				
ᅙ	ages of of t: If if		1 ☐ Burial 2 ☐ Cremation 3 i 4 ☐ Donation 5 ☐ Other (Spec		n State		natory or other p	tory 05/	13/2006	Cumbe	rland	MΤ		
Baltimore,	rtme ortan njury		21. Signature of Fineral Service Lice		Cu			- 1				Home, P.A.		
Ba	Department of the partment of		I folit C. C	Elam	/				et, Cumbe	,		1502		
г			23a. Párt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Construction and Interval Between Construction a											
	Physician													
	/Medical	resulting in death) Due to (or as a consequence of):												
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õ	Attending Physician: The law requires that the death certific refath. r death. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant		utcome of pregr birth 2 Fet		Ectopic pregnar	псу			ate of delive	•		
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0	ding Physician: h. After this certific funeral director,	ī.	27. Manner of Death	28a. Date	e of Injury oth, Day Year)	28b. Time of	28c. tn	jury at	28d. Describe					
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	s afte	Certification:	TO HOLD	Date	unig, etc. (opec				Oily or 100	mi, State)				
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	edicai (29a. Certifier 1 🖔 Certifying P (Check only one)	miner: On the	ne best of my kr basis of examin nner stated.	owledge, death ation and/or in	occurred at the restigation, in m	time, date and pla y opinion, death oc	ce, and due to the curred at the time,	cause(s) and m date and place	anner as st	ated. the cause(s)		
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	w,		Shiv C.	Khanna	, M.D.,	1221	Nationa	1 Highwa	y, LaVale	, Mary	land	21502		
	Sta		31. Date filed (Month, Day, Year)	32.	Registrar's Sign	ature	<i>A</i>							
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State of Maryland / Department of Health and Mental Hygiene 0 6 State Registra AMEND#31see#32;5/12/06,EMW,MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Florence Watson May 3, 2006 9:12 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Months Days Hours Min. 88 Yrs. Director 12,1917 Lynchburg. 578-20-4313 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Forestville Maryland Prince Georges Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20747 1948 Rochelle Ave. Apt. 322 United States filed within 72 hours after death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ 3 Widowed 4 □ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ai Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Tech George Washington Hosp 12th permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygies
Important: if item 27 is marked other ti
any injary or other traumatic event. Im 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Granddaughter) 303 Buckmill Circle Waldorf, MD 20602 Anita Kyle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/27/06 Resurrection Cemetery Clinton, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street NW Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Gastrointestinal Hemorrhage **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 🗆 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) -1 of person who completed cause of death (Item 23a) (Type, Print) Outres 1500 Forest Glen Road Silver Spring, MD 20910 - HWRENC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 2 2006 Registrar

State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Year **Physician** May 9, Shuen Hwa Wang 2006 4:36 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fairland Adventist Nursing & Rehab. Silver If Under 1 Year Spring Montgomery 8. Date of Birth (Month, Day, Year) Oct. 16, 1 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2 F Months Hours 452-43-9953 87 Yrs 1918 China Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or items 23a or 28a-f show the Medical Examiner must be notified at 1 TYes 2X No Director Maryland Montgomery North Potomac 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 15557 Ambiance Drive 20878 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify SpecifyAsian þ 3 XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other then " Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemake r Own Home injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hiant: if item 27 is marked other. Be Kang Chen Jean Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Wang/ Son 15557 Ambiance Drive, North Potomac, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) May Date 15, 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: if eny injury or once. 2006 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 endo Part 1. Sinter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Coronary Syndrome Immediate /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, physician Completed by Physician/Medical the page 2 should be detached for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the Ó 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 🗌 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 🔀 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) May 11, 2006 29b. Signature and title of certifier 29c. License number May 11, D28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ravi Passi, M.D. 8609 Second Avenue, #404B, Silver Spring, MD 20910 Ravi Passi, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yeer **Physician** May 10, 2006 Purnell Quillin Wolf 1:35 /Medical 4c. County of Deeth 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Wicomico 210 Kay Avenue If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛛 F 92 214-10-7483 Yrs Director 11/05/1913 Maryland Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23s or 28s-f show try or other than the Medical Examinar must be notified at ury or other traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10a, State 10d. Inside City Limits Salisbury Maryland Wicomico 1 ☐ Yes 2X No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21801 USA 210 Kay Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clinton E. Wolf Beulah Purnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kaye Wycall/daughter 424 Rolling Rd., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If sny injury or once. 5/13/06 `4 □ Donation 5 ②Cother (Specify) Entombment

21. Signature of Funeral Service Lic. (See Parsons Cemetery Salisbury, MD 2. Name and Address of Facility Holloway Funeral Home Professional Association Mett. 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOMA OVARIAN META STATIC **Physician** 6 MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ DEGENERATIVE JOINT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should **Be Completed** STE NOSIS 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No OBSTRUCTIVE CHRONIC LUNG DISEASE 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Mesidence} \) 6 \(\text{Other} \) (Specify) Certification: To 1 Yes 2 No 3 DOA funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funerel Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Fune 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46962 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WINTERPLACE PARKWAY. M. SHIRAZI, M.D. 31575 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** GLADYS N WARNICK MAY16. 2006 9:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ST VINCENT de PAUL NURSING CENTER **FROSTBURG** ALLEGANY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year 10-Oct-1904 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1□M 2XF Maryland 217-10-6367 101 **Director** Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10a, State 10d. Inside City Limits rthen "naturel", or items 23a or 28e-f show Ite Medical Examiner must be notified at 1 Yes 2 No Frostburg Be Completed by Funeral Director Maryland Allegany 10e. Street and Number 138 Washington Street 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21532filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Importent: If item 27 is marked other th any injury or other treumatic event, IIIs once. 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Daniel P. Nightengale Margaret Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45 Bowery Street Wanda Langley daughter Frostburg Maryland 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 19-May-2006 Frostburg Frostburg Memorial Park Maryland `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart **Physician** 2 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 No 1 Yes 2 XNO Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DQA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Worsocksten May 16, 2006 00055325 MD

Registrar
DHMH 17 Rev 1/2001

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48 Turn Tenace

32. Registrar's Signature

Frostburg

MD 21532

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MD

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** A. M. MAY 21 WILLIAMS 2006 6:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** FOREST HILL HEALTH & REHABILITATION FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 10/6/1921 9. Birthplace (State or Foreign County) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 📉 M 2 🗆 F 235-30-3476 Director 84 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or Itams 23a or 28a-1 show The Medical Examinar must be notified at Harford Street 1 ☐ Yes 2 XNo MD Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21154 3325 Scarboro Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give 1942–45 Year or Dates: 1942–45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygient Important: if item 27 is marked other the any injury or other traumatic and once. Civil Service Explosives Operator 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nina Morrison Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3325 Scarboro Road, Street, MD 21154 Doris Jean Williams/Wife 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 5/24/2006 Street, MD Ascension Cemetery 21. Signature of Funeral Service Licentee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 n. Englished isea e, or complitations that caused the weath. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or neart failure. List only ne cause on each line. Approximate Onset and Death Immediate Cause (Final lie Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 Yes 1 Tyes completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Deve 5 D 0 32275 may 72, 200 (30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN - 615 W. MACPHAIL ROAD - STE. 106 - BEL AIR, MD 21014 34. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 5 2006

			For State Registrar	State	of Marylar		artment of H		and Me		gienez (006	167	88	
	Dhysioi	¥	1. Decedent's Name (First, Middle,	Last)						2. Date of De Month	Day	Year	3. Time of	Death	
	Physicia /Medic		Santina M. Wes							May 8	1		4:15	P ^M	
	Examin		4a. Facility Name (If not institution,		·		4b. City, Town, or		of Death			4c. County of Death			
			Anne Arundel Med 5. Social Security Number	lical Cen	7. Age (In yrs.	last birthday)	Annapo	If Under:	24 Hrs.	8. Date of Birt	Anne Arundel Birth 9. Birthplace (State or Foreign				
	Funeral Director		577-38-8587	1 □ M 2 X) F	75	Yrs.	Months Days	Hours	Min.	8. Date of Bird (Month, Da 12-24-	y, Year) 1930	Cou	hingtor		
	ס		Usual Residence of Decedent												
	arylar show	_	10a. State 10b. County		10c. Cr	ty, Town or Lo							10d. Inside Cit 1 X Yes	-	
	he Mi Sa-f	Directo		Arundel		Anna	polis 10f. Zip Code				10g. Citizen o	4 M/h - 4 C - 11			
	death with the Maryland rms 23s or 28a-f show r must be notified at		10e. Street and Number 1024 Spa Rd.,	Apt. A			21403	}			USA		muy:		
	ns 23	Funerai	11, Marital Status	12. Was Dec	edent Ever in U	I.S. 13.	Was Decedent of H	ispanic Orig	gin? (Spec	cify Yes or No			ican Indian,		
٥	after or item		1 Never Married 2 XMarrie	Armed F	orces? 2XXVo ive		If Yes, specify Cuba	in, Mexican Specify:	n, Puerto P	lican, etc.)		ack, White			
2-003p	72 hours after natural', or ite dical Examina	d by	3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates:		1 ☐ Yes 2 X No	эрөспу.			Spec	://y: VVII	ite		
	n 72 h	iete	15. Decedent's (Specify only highest)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most	t of workin	g	16b. Kind of	Business/Ir	ndustry		
7	s filed within 72 hours after death with the Marylan I Hygiene. other than "natural", or items 23a or 28a-f show ont, the Madical Examinar must be notified at	Completed	Elementary/Secondary (0-12) 12th	College	(1-4or 5+)		emaker	′/			Но	me			
and	Hys Hys othe	a)	17. Father's Name (First, Middle, L.	ast)		12011		18. Mothe	er's Name	(First, Middle,	Maiden Suma				
lar		To B	John Gig	liotti				Al	bina	Cento	celli				
Jan	ges 1 and 2 should it of Health and Mer it item 27 is marke or other traumatic		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Maili	ng Address (Street a	a <i>nd Numb</i> e			aruus seura				
e,	1 and Health em 27 ther ti		George H. West/ 20a. Method of Disposition	Husband	20b. F		Spa Rd , sition (Name of matory or other place	Apt.	A, 1	Annapol	20c. Location	2140	own. State		
nor	Pages nent of I nnt: If ite ury or o		1 ☐ Burial 2 ☒ Cremation :		State	_	matory or other place rematory		5-10-		Edgewa	,			
gaitimore,	+ E # .		21. Signature of Funeral Service L		140		2. Name and Addres	,						2	
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ľ			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that nly one cause on	caused the deat	th. Do not en	ter the mode of dyin	g, such as	cardiac or	respiratory a	rest,		Approximate Interval Betw	/een	
	Physician		Immediate Cause (Final disease or condition	<u>a. S</u>	epsi	5							Onset and D	eatn	
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):									
k		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or white years	b. Due to	(or as a consec	uence of):	a								
	outed id ansit	Examiner	cause. Enter Underlying Cause Disease of July that initiated events	C.											
Ď,	e exer		resulting in death) Last	Due to	(or as a consec	quence of):									
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XOR	d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1□Live 4⊡Preg	birth 2 ☐ Feta nant at time of c	al death 3	Ectopic pregnancy Other (specify)				l l	fonth	*	ear	
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	ysicia is cert directe	0 B	examiner?	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Othe	or		(Check only o	<i>ne)</i> dence 6 □O	ther (Sneci	fu)		
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Š	Attending Physician: or death. ector: After this certific by the funeral director,	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	ition	nin, bay roary	Injury		Yes 2 ☐ I	No						
DIVISION	± ± ±	Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Plac build	e of Injury - At h Jing, etc. <i>(Speci</i> i	ome, farm, sti fy)	reet, factory, office		21	8f. Location (5 City or Tox		nber or Run	al Route Numb	99 <i>1</i> ,	
	urs era		29a. Certifier 1 Certifying	Physician: To th	a heat of my kno	nwledge deat	h occurred at the tim	ne date an	d place, as	nd due to the	causo/s) and n	20001 25	stated		
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	(Check only 2 Medical E	xeminer: On the l	basis of examina nner stated.	ation and/or in	vestigation, in my or	pinion, deat	th occurre	d at the time,	date and place	, and due t	o the cause(s)		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 9:00 A M Irginia May 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore University of Maryland Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, FEB 19, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days 1 ☐ M 2 1 F Hours Tennéssee 79 Yrs. 409-50-1702 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other then "neturel", or fleme 23a or 28a-1 show treumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 X No Director Rising Sun Maryland Cecil 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21911 United States 343 Chrome Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) In Her Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Conpbee Will Vance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a 343 Chrome Road, Rising Sun, Maryland 21911 Edgar Curtis McCoy/Son Department of Health Important: if item 27 any injury or other tr ouce. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition May 24, Christ Community 1 Burial 2 Cremation 3 Removal from State West Grove, 4 □ Donation 5 □ Other (Specify) Fellowship Cemetery Pennsylvania 21. Signative of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) Physician acute mesenteric ischemia 48 hours /Medical Due to (or as a consequence of): Examiner unerosclerosis MAKEGON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 XInpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Intury s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Momicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 24 hours To the Fune completely file 29a. Certifier To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 064246 KNIMBRINE MI 30. Name and as ress of an eson who completed cause of death (Item 23a) (Type, Print) Kimberly M Lumpkins MD 225 Greene St Baltimore MD
31. Date filed (Month, Day, Year) 33. Registrar's Signature State Registrar MAY 2 6 2006 DHMH 17 Rev 1/2001

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	Physici	an	Decedent's Name (First, Middle,	,				-	2. Date o Month May	f Death	v Year	3. Time of Death
	/Medic	al	MILKA 4a. Facility Name (If not institution,		m ber)	YAR	LOVSKY	or Location of D			, 200	
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	deati	Funeral	11. Marital Status		edent Ever in l		Was Decedent of	Hispanic Origin?	? (Specify Yes o	r No-	14. Race - Am	nerican Indian,
9	or Ite	/ Fu	1 Never Married 2 Marrie		2 🛛 No		If Yes, specify Cu 1 ☐ Yes 2 🔀 N		uerto nican, etc.	,	Black, Wh	ite, etc.
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<u>a</u>	should be ind Mental I	ToE	GEORGE		KRENT				MARIA]	DAVIDOV	Α
Maryland	2 she and is m		19a. Informant's Name/Relationshi				ng Address (Stree					
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Baltimore,	permit. Pages Department of H Important: If Its any Injury or of		1 ☐ Burial 2 🛱 Cremation :		State	cemetery, crei	natory`or other pi	1			ocation - City o	
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n	Dep Imp any		12/11/01	// //	M 00	091 CH	Name and Add HAMBERS 301 CLEV	FUNERAL	HOME &	CREMA'	TORIUM,	P.A.
*	*		23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that only one cause on	aused the dea	th. Do not ent	er the mode of dy	ring, such as care	diac or respirato	ry arrest,	is riv.	Approximate Interval Between
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	/Medical Examiner		resulting in death)		(or as a conse			201.0	7 10 1 11			0 20 5 5 1 3
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	ted nslt	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	00010	(or as a consec	quence or):						
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X OZ	iaw requires that the death certit as been signed by the attending 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, out 1□Live b	tcome of pregn		Ectopic pregnan	cv			23d. Date of de	*
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DIVISION	or At after of Direct in by	ertification:	4 Homicide determin	ed 286. Place	of Injury - At h ng, etc. <i>(Speci</i>	ome, farm, str fy)	eet, factory, office		28f. Locatio City or	n (Street an Town, State	d Number or R)	lural Route Number,
_	spital iours neral filled	0	29a. Certifier 1XCertifying	Physician: To the	best of my kno	owledge death	occurred at the t	ime, date and nis	ace and due to t	the cause(s)	and manage as	a stated
	To the Hospital or Attending Physician: which 24 hours after deals as a feet deals To the Funeral Director: After this certifica completely filled in by the funeral director; t	edical	(Check only 2 Medical Ex	caminer : On the ba	asis of examina	ation and/or inv	estigation, in my	opinion, death or	ccurred at the tin	ne, date and	d place, and due	to the cause(s)
	To ti To ti Comp	M	29b. Signature and title of certifier				29c. Licen	ise number			te signed (Mont	
	D		Dhum, th	own,	MD		000	2885	8	0	5110	106
-			30. Name and address o person w					ED	T.O	0.170	. •	
5			DR. FLORIN 31. Date filed (Month, Day, Year)	RUSU,M.D.	egistrar's Signa	aturo	7th ST.	, FREDER	IICK, MD	. 2170) [
1.7	Sta Registr	74		2006	- grower a digiti	1 Aug	ule					

			riease	State of Marylar					•		•	16701
			1 - For State Registrer	Otate of Marytar			ite of De		_	Reg. No.		16/91
			Decedent's Name (First, Middle, La	st)					2. Date of De	ath		3. Time of Death
	Physici		Wanda	Lorraine Yode	r				Month May	13	2006	0345 M
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. Ci	y, Town, or Loc	ation of Death		4c.	County of Death	
			Harford Memoria	l Hospital	_	1	Havre d				Harfor	
	Funeral		5. Social Security Number 6. S 213-26-3226	ex 7. Age (In yrs. □ M 2⊠ F 76	last birthday) Yrs.	If Und Month		Under 24 Hrs. lours Min.	(Month, Da	th y, Year)	9. Birth	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	76	115.				July 10	J, I	929 M	aryland
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	Man,	tor	Maryland Ceci:	_			Perryvi	11e				1 X Yes 2 ☐ No
	h the	Funeral Director	10e. Street and Number			10f. 2	Zip Code			10g. Citi	zen of What Cou	ntry?
	th will	alD	603 Concord Apart	ments			2	1903			U.S.A.	
	sms ams	iner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was De	edent of Hispa becify Cuban, M	nic Origin? (Sp lexican, Puerto	pecify Yes or No Rican, etc.)	-	14. Race - Ameri Black, White,	
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 🌣 Widowed 4 ☐ Divorced	1 □Yes 2 🖾 No If Yes, Give				pecify:			Canalta	hite
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Itams 23a or 28a-f ehow the Madical Evartinal must be notillised at	q pa	15. Decedent's E	Year or Dates:	16a Dece	dent's H	sual Occupation	2		16h Ki	nd of Business/In	
15	in 72 in na in realic	Completed	(Specify only highest gra	ade completed)	(Give	kind of i	vork done durin use retired)	ng most of work	king		Medica:	,
212	iene.	шо	Elementary/Secondary (0-12) Nine Years	College (1-4or 5+)	Lá	aund	ry Serv	ice		Perr	y Point	Maryland
b	othe othe vent,	Be C	17. Father's Name (First, Middle, Last)			18.	Mother's Nam	e (First, Middle,	Maiden	Sumame)	
/lar	Venta Venta rrkad rrkad	ToE	Samuel	Painter				I	Chelma C	ampb	ell	
Maryland	and l		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Addre	ss (Street and	Number or Rui	ral Route Numbe	er, City o	r Town, State, Zip	Code)
≥,	and ealth m 27 her tr		Ruth A. Mayton (I						-		, Maryla	
Ore	ges 1 t of H If ita or otl		20a. Method of Disposition 1 □ Burial 2 🏝 Cremation 3 □	Removal from State	Place of Dispo cemetery, cre	matory o	r other place)	l I	Date		cation - City or To	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Items 23a or 28a-f show amportent: If item 27 is marked other than "natural; or Items 23a or 28a-f show any righty or other traumatic event, the Medical Examination must be notified at Once.		* 4 ☐ Donation 5 ☐ Other (Special	"			b., Inc.	1	/14/06	West	Chester,	Pennsylvania
Bal	Deparenti Deparenti Importanti Eny ir		21. Signature of Funeral Service Lice	TSOO A R WELL	<_ Le	ee A		rson &			. Home, 1	P.A.
16	402.0		23a Part Fotor the disease or com	plications that caused the dea	th Do not en	erry	ville,	Marylar	nd 2190	3-07	66 _	Approximate
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	/ '-		1	odo or dynig, or	2011 23 021 0120	or respiratory as	11031,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Due to (or as a consec	-	- 111	19					3 days
	Examiner			Due to (or as a consec	district of).		1(%)					0
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quence of):							
	eath certificate be executed attending physician and for use as the burial-transit	Examin	that initiated events	C								
,092	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a consec	quence of):							
978	ate by hysic the bu	licai		d								
89 x	ling p	Physician/Medi	IF FEMALE:	OZa If you system of second								
Box	attend attend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of	at death 3	Ectopic Other	pregnancy			2	23d. Date of delive Month	ery Day Year
o.	the de	ysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9☐ Unknown	Jean St	_ Ottiel (specily)					
Δ	that the de led by the detached	y Ph	Part II. Other significant conditions	contributing to death but not re-	sulting in the u	inderlying	cause given in	Part I.	23e. Did to	obacco u	se contribute to t	ne cause of death?
sp.	w requires that s been signed to should be det	d by							1 🗆 1	res 2[□No 3 Prot	ably 4 Unknown
Records,	w reg	Completed							24a. Was		24b. Were auto	psy findings available
Re	The ta te has age 2	mo								rmed?_	prior to co death? 1 \(\subseteq \text{Yes}	mpletion of cause of
ta	an:] tiffical tor, p	BeC	25. Was case referred to medical				26	. Place of Deat	1 ☐ Yes th (Check only o	2 No	1 165	20110
Division of Vital	Physician: r this certificatal director,	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2] ER/Outpatie	nt 3[OCA Other:	4 ☐ Nursing Ho	ome 5 🗀 Resid	dence 6	S □Other (Specif	y)
0 4	ng Ph Iter th neral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f	28c. Injury at Work?		28d. Describe h	now injur	y occurred	
Sio	endia path. or: A he fu	Certification;	2 Accident investigation	n		М		2 🗆 No				
Ξ	her direct	ŧ	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, st fy)	reet, fact	ory, office		28f. Location (S City or Tox		d Number or Rura)	I Route Number,
	pital urs a eral C		On Orabina AFRICATION	To the best of the least			and an all an all an ar-					
	Hos Pun Fun	Medical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exer	nysician: To the best of my kn niner: On the basis of examinated and manner stated.	ation and/or in	n occum vestigati	on, in my opinio	on, death occur	red at the time,	date and	place, and due to	the cause(s)
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier	Marino diatodi		- 2	9c. License nu			29d. Date	e signed (Month,	Day, Year)
	- > → ō		> la lian	mp			D32	609		51	13106.	
	,		30. Name and address of person who		m 23a) (Type,	Print)			0			
_	(e)		Kamudey	Milliam M	o live	Re	volution	n St t	awra D	e UR	rolle mi	24078
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature 4	mark			•			

			1 - For State Registrar	State of Maryla		artment of I			ene 006	16792
20	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yea	3. Time of Death
Y.	/Medic		Terry	L. Arrick					2006	1:20 A M
	Examir	er	4a. Facility Name (If not institution, give 1950 Melvin Drive	street and number)			or Location of De	ath	4c. County of De	ath
1,00						Edgewo			Harfor	db
	Funeral		5. Social Security Number 6. Se 219–60–5400	7. Age (In ye	rs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, Day, Y	(ear) 9. 8	inhplace (State or Foreign Country)
e.	Director		Usual Residence of Decedent	55				Jan. 22,	1953 м	aryland
	land bw ff		10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
	Mary	Į,	Maryland Harfor	rd	Edgew	ood				1 ☐ Yes ♣♠No
	28a	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What (Country?
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show sdical Examinating the notified at	0	1950 Melvin Drive			21	040		USA	•
	death	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of I	Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - An	nerican Indian,
9	or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo				erto Rican, etc.)	Bfack, Wh	
03	ral', c	b	3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Dates:		1 □ Yes XXX No	Specify:		Specify: V	Mhite
21215-0036	in 72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Occup	oation during most of w	rorking 16	b. Kind of Busines	s/Industry
21	within lene. than "	du	Elementary/Secondary (0-12)	Coflege (1-4or 5+)		kind of work done DO NOT use retire	d)	1		
7	filed w Hygier other th	õ	6		HOM	emaker			vn Home	
P	o e e	Be	17. Father's Name (First, Middle, Last)	_				ame (First, Middle, Ma	,	
<u>\</u>	should be nd Mental marked o	ပို	James A. Arric	•				ry A. Weima		
Maryland	S se se		19a. Informant's Name/Relationship (T) Stacey Bowles	_{грө, Print)} Daughter				Rural Route Number, C		
	s 1 and 2 f Health itsm 27 other tra					2 Johahn 1 osition (Name of	Drive We	stminster,		
0	of of or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		cemetery, cre-	matory or other pla	ce) E / 3/		c. Location - City o	
Ë			4 □ Donation 5 □ Other (Specify)			Cemetery		0/2006 Ba	artinore,	Maryland
Baltimore,	permit. Pag Department Important: any injury c		21. Signature Funeral Service Licens	enss	Bi	^{2. Name and Addre urgee—Her 631 Falls}	ess of Facility 188-Seitz 8 Road 1	z Funeral H Baltimore,	Home, Inc	. 21211
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the de	ath. Do not en	ter the mode of dyir	ng, such as cardi	ac or respiratory arrest	,	Approximate Interval Between
Ш	Physician		Immediate Cause (Final disease or condition		Delu	schale	an			Onset and Death
п	/Medical		resulting in death)	Due to (or as a cons		1	-	11 0		2 W Cens
8	Examiner		Commented link and distance	Ad	vanc	ed 1	ousi	clar Car	cinong	2 years
	n =	ner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					U
$\sqrt{}$	The law requires that the death certificate be executed tie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Examin	triat initiated events	o						
Ö,	e exe ien a urial-		resulting in death) Last	Due to (or as a cons	equence of):					
8760,	ate b hysic the bi	Icai		d						
9	ing pl	Physician/Medi	IF FEMALE:							
Вох	eath certific attending p	an/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy	,		23d. Date of d	•
	he al	SICI	1 ☐ Yes 2 No	4☐Pregnant at time o 9☐ Unknown	f death 5[Other (specify)			Month	Day Year
P.O	that the de ed by the detached	Phy	9 Unknown							
	res th	þ	Part If. Dther significant conditions con	ninbuting to death but not r	esuiting in the u	nderlying cause giv	en in Part I.	V	_	to the cause of death?
0.0	w require been si should b	Completed						1 Yes	2 No 3 F	Probably 4 Unknown
ec	e law has b	ple						24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
= H		Con						performe 1 ☐ Yes 2 2	d? death?	
/ita	cian: ertific actor,	Be	25. Was case referred to medical examiner?					eath (Check only one)	-	
7	Physicia this cert	은	1 □ Yes 2 No		☐ ER/Outpatier		4 🗆 Nursing	Home 5 Residence	e 6 □Other (Sp	ecify)
ū	ding P h. After i funere	atlon:	27. Manner of Death 1 △Naturaf 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	y at k?	28d. Describe how	infury occurred	
sio	death ctor: /	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Division of Vital Records,	I or Attending Physician: after death. Director: After this certification by the funeral director;	Certific	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or F State)	Rural Route Number.
	pital ours a eral [One Continue 12							
	To the Hospital or Attu within 24 hours after de To the Funeral Directo completely filled in by th	edical	29a. Certifier Certifying Physical Check only one)	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the caus curred at the time, date	e(s) end manner a and place, and du	as stated. le to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and mainter stated.		29c. Licens	e number	29d	Date signed (Mor	nth. Day. Year)
	⊢s⊢ŏ		Suman 1/2	0			7703		1291A	1
	í		30. Name and address of person who co	mnleted cause of death //	om 22a\ /T				1-11	_
	6			impleted cause of death (It		SQUARE.	DRIVE	, BALTIN	MORE,	MD 21237
	Sta Registr		31. Date filed (Month, Day, Year) MAY 3 0 200	32 Registrar's Sig	nature	W.		BALTIN		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Des Year **Physician** Mac 20 206 /Medical 4b. City, Town, or Location of Dodth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner N/A NUYSIN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 12, 1926 Mary Land Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Deys Hours Months 1 □ M 2 🖾 F 79 June Yrs. 216-20-6470 Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a Stete permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at 1X Yes 2 No Director N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 5501 Plymouth Road 21214 USA Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 € No Specify. Specify: white Baltimore, Maryland 21215-0020 Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Retail Accounting 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Edward W. Perry Ethel Turner 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5501 Plymouth Road Baltimore, MD 21214 William Avig, IV- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5/30/06 Baltimore, MD Moreland Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6415 Belair Road Baltimore, MD 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician wheth mia. Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner for use as the burial-transit Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 3 Probably 4 ☐ Unknown 1 Tyes 2 No Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Ves 24Z No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Vivursing Home 5 ☐ Residence 6 ☐ Other (Specify) edical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Date of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Menner of Death 1 D Naturet 28c. Injury at Work? After Division 5 Pending 1 ☐ Yes 2 ☐ No after death.

Director: Af d in by the fu investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b 6 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier rours who completed cause of death (Item 23e) (Type, Print) 32. Registrer's Signeture State

Registrar

			for State	State of Ma		-	artmer	nt of H	lealth ar		•		-	e e	1670	gr ^m
			1 - State Registrar			Cei	TITICAL	e ot l	Death			eg. No	ok UU	b	10/9	U
Н	Physici	an	Decedent's Name (First, Middle, Last								2. Date of Dea Month	Da		eer	3. Time of Death	
	/Media		Doris H. Arno				4h Cilv	Tour	Location of	Death	May 2		2006_c. County of	Dogth	10:45P	_
	Examin	er			20		_		_	Death			•			
	Funeral		701 Fallsgrove 5. Social Security Number 6. S			last birthday)		kvil. riYear	Le If Under 24	4 Hrs.	8. Date of Birth	1	Montgo	omer . Birtho	y lace (State or Forei try)	ian
	Director			□M 2TxF	75	Yrs.	Months	Days	Hours	Min.	Month, Day	Year,	930	Coun	ryland	,
	P.		Usual Residence of Decedent						-							_
	arylar show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo								1	Od. Inside City Limi	
	8a-f	50	Maryland Montgom	ery				cvill	.e						1 ☐ Yes 2 ☒ N	10
	vith th	洁	10e. Street and Number	mirro #200			10f. Zip		150		1		itizen of Wh		•	
	s 23s	by Funeral Director	701 Fallsgrove D	12. Was Decedent	Ever in 11	C 12.1	Mas Dasa	208		2/520	ifu Von or No	Ur	ited			_
	Her d	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Amed Forces?		.3.	f Yes, spe	cify Cuba	n, Mexican,	Puerto R	ify Yes or No- ican, etc.)			White,		
93	urs a	þ	3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	2 🔀 No	Specify:				Specify:	W	nite	
2	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or itams 23e or 28e-f ehow event, the Medical Examinat must be notified at	Completed	15. Decedent's Ec (Specify only highest gra			16a. Deced	dent's Usu	al Occupa	ation	of working	2	16b. H	Kind of Busin	ness/Ind	lustry	_
Maryland 21215-0036	ithin	ğ	Elementary/Secondary (0-12)	College (1-4or 5	i+)				during most of Office			E a d	1 1	0		
2	ygier ygier her th	ပ္ပ	12			Admin	TPLIC	LLIVE						GOV	ernment	
and	be fi	Be	17. Father's Name (First, Middle, Last) Lewis Hankel								<i>(First, Middle, I</i> Bowman	Maidei	n Sumame)			
ž	d Mer nark	٩	19a. Informant's Name/Relationship (1	Suna Print)		10h Mailin	a Addras	/Street					T C4	-4- 7:-	0-4-1	_
<u>B</u>	d 2 s th an 17 is i		Lisa Henry/Daughte								Route Number 1, Boyd					
ā,	Heal Heal tem 2		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	ne of	1	Da	te		ocation - Ci			_
JOE	ages ent of t: If I		1 ⊠Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Pa	emetery, cren rklawn Park	Memo	rial	θ)	June 2006	2.				aryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural; or Items 23s or 28s-1 show importent: If Item 27 is marked other then "natural be notified at any injury or other traumatic event, the Medical Examinat must be notified at ange.		21. Signature of Funeral Service Licen			The 2 I S 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Name ar	nd Addres			_				lle, Inc	_
ä	Depermine Depermine Permine Pe		Ky Jen		M001	98 30	0 Wes	t Mor	rumpnr itgome	ry Av	unerai 7e Roc	HOI kv:	me/Roc ille.	KVI MD 2	11e, Inc. 0850-2805	•
			23a. Part1. Enter the disease, or company shock, or heart failure. List only	olications that caused	the deat										Approximate Interval Between	
	Physician	6 1	Immediate Cause (Final disease or condition	Malignan										D	Onset and Death iagnosed	
	/Medical		resulting in death)	Due to (or as				Jeas.	20 00 1	ilear	c, hang	J			2/11/04	_
ı	Examiner		Sequentially list conditions	b											5 5	
d	Si g	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseq	uence of):										
10	icate be executed physicien and s the burial-transit	Examin	that initiated events resulting in death) Last	c Due to (or as	a conseq	Lience of):										
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687	icate phys s the			d												
×	that the death certifical ed by the ettending phi detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date of	f delive	rv	
Вох	d for	cial	in the past 12 months?	1□Live birth 4□Pregnant at			Ectopic po Other (sp						Month		Day Year	
P. 0.	t the by the ache	hys	9 ☐ Unknown	9□ Unknown												
	The law requires that the death certifica He has been signed by the ettending ph age 2 should be detached for use as th	by P	Part II. Other significant conditions of	ontributing to death be	ut not res	ulting in the ur	nderlying o	ause give	n in Part I.		23e. Did tot	acco	use contribu	ite to th	e cause of death?	
of Vital Records,	en sig	ed								_	1 □ Y€	es 2	⊠No 3[] Proba	ably 4 ∐Unknow	n
OC O	has be	Completed									24a. Was a autops		24b. Wei	e autop	sy findings availab	ie
<u> </u>	The ete h page	Соп									perform	ned? 2⊠No	dea	th? Yes		
/ita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?							f Death /	Check only on	θ)				
5	hysi this c	은	10 195 2210	Hospital: 1 ☐ Inpatie		ER/Outpatien			4 🗀 1901 3		e 5⊠ Reside			Specify)	
5	After After funer	o	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Da)	Year)	28b. Time of Injury	M 2	8c. Injury Work			ld. Describe ho	w inju	ry occurred			
Division	Attending or death. ector: Afte by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be		ını - At hı	ome farm etre			res 2 □ No		If Location /St	root ar	nd Number	r Pura	Route Number,	
<u>~</u>	or A efter Direction by	Certification:	4 ☐ Homicide determined	building, etc			ooi, lactory	, once		20	City or Town	, State	B)	or murai	noule Number,	
	To the Hospitel or Attending Physician: The within 24 hours effer death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Ph	ywcian: To the bast o	of my kno	wiedge, death	occurred	at the tim	e, date and ;	place, an	id due to the ea	us als	and mann	er as ste	Kad.	
	n 24 h	edicai	(Check only 2 Medical Examone)	iner: On the basis of and manner sta	examina	tion and/or inv	restigation	, in my op	inion, death	occurred	I at the time, da	ate and	d place, and	due to	the cause(s)	
	within To the	ž	29b. Signature and title of certifier				290	. License	number		25	9d. Da	te signed (A			
)			James Els	ac Concy	me	me	9	I)43254				5	120	106	
	10		30. Name and address of person who							0.50					10000	
	,		Lauren Elise Cosg				card	Driv	re, Ro	ckvi	lle, Ma	ry]	land 2	085	0	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 3 0 200	2. Registra	ar s Signa	dosa	Ke									

			1 - For State Registrar	State of Marylar		artment of I		F	Reg. No.	16797
п	Physici	an	Decedent's Name (First, Middle, Las					2. Date of Dea Month	Day Year	1.4
	/Media	al	Hazel 4a. Facility Name (If not institution, give	Breneman		4h Cihi Toum	or Location of Deat	May	26 2006 4c. County of De	8:15 A M
	Examin	er	8295 Waterford Ro					11		
	Funeral		5. Social Security Number 6. Se	x 7. Age (In vrs.	last birthday)	Pasadei If Under 1 Year	If Under 24 Hrs		Anne Ar	thplace (State or Foreign country)
ы	Director		217-12-8889	□M 21X1F 8	3 Yrs.	Months Days	Hours Min.	August	31,1922	Maryland
	pu k		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	filed within 72 hours after death with the Maryland Hygiene. Ither then "natural", or items 23e or 28e-(show ent, it e Madical Examinar must be notified a	ō								1 ☐ Yes 2 ☑ No
	the A	Directo	Maryland Anne Art	indei	Pas	adena 10f. Zip Code			10g. Citizen of What C	country?
	3a or	ā	8295 Waterford	d Road		2.	1122		US	۸.
	death death	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H		specify Yes or No-		erican Indian,
9	after or its	.E	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🕅 No		1 □ Yes 2 X No	Specify:	to Hican, etc.)	Black, Wh	
21215-0036	nours urai',	d by	3 🖾 Widowed 4 □ Divorced	If Yes, Give Year or Dates:						
ب	n 72 l	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of Busines:	s/Industry
12	withi iene. then	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		erical	-,		A A Boar	d of Educ.
ğ	other	Be C	17. Father's Name (First, Middle, Last)			or rour	18. Mother's Nar	me (First, Middle,	Maiden Sumame)	d OI Luuc.
퍨	uid be Menta rked ric e	To B	Ellsworth Frank	din Milhollan	d		Viva	V. Bento	n	
Maryland	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of the mary is marked other then "natural; or items 23a or 28a-f ahow eny injury or other treumatic event, it a Madical Examinar must be notified at once.		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street	and Number or Ru	ıral Route Numbe	or, City or Town, State,	Zip Code)
`,	end lealth m 27 her tr	į į	Terry Breneman -		82	95 Wateri	ford Rd.,	Pasaden	a, MD 2112	2
Baltimore,	ges 1 it of H if its		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crei	osition (Name of matory or other pla	l l		20c. Location - City o	
<u>‡</u>	it. Pa		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Server Done		the second secon	en Cemete 2. Name and Addre			Glen Bur	
Ba	Depa Impo eny is		21. Signature of Pullera Celves Sca		-		J		Funeral H a, MD 2112	
			23a. Part1. Enter the disease, or comp	lications that caused the dea						Approximate
	Physician		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	Parto	Carola	Vascula	in As	ease	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consec	nence of):/	So.	Descule Pulmor	1010	\	
	Examiner		Sequentially list conditions	o. Chronic (bstn	actibe (Kulmore	my 000	lan	
I	si si	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):			0		
Ĺ	and and Il-tran	хап	that initiated events resulting in death) Last	c Due to (or as a consec	uence of):					
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687	ificate g phy as the		***	u						
Box	eath certific attanding p	M/us	23b. was decedent pregnant	23c. If yes, outcome of pregn. 1⊟Live birth 2 ⊟ Fete		Ectopic pregnanc	,		23d. Date of de	
	e deal he att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of o		Other (specify)			Month	Day Year
o O	that the de led by the a detached t	Phy	9 ☐ Unknown Part II. Other significant conditions co		ultina in the	- db-i	on in Dard I	220 Did to	bacco use contribute	to the enum of death?
ds,	ires tha signed d be del	d by	Partin. Other significant condutions of	intributing to death but not res	sulting in the u	ndenying cause giv	eri in Fatti.	1 🗆 Y	_ /	robably 4 Unknown
, S	w requir been si should	etec						24a. Was a		
Records,	he lav e has	Completed						autop perfor	sy prior to death?	
Vital	ificate or, pa	ပိ	25. Was case referred to medical				26 Place of Dec	1 ☐ Yes ath (Check only or	2 No 1 Ye	s 21 No
	ysici is cer direct	ToB	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Ott	or	/	ence 6 Other (Sp	ecify)
0	*Attending Physician: The isr death. **Coor. After this certificate he by the funeral director, page		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injui Wo			ow injury occurred	
<u>S</u>	fendii leath. tor: A the fu	catle	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No			
É	or At after d Direct in by	ertification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, tarm, str ly)	reet, factory, office		28f. Location (S City or Tow	itreet and Number or F n, State)	lural Route Number,
	spital ours a nerel l	O	29a. Certifier 1 V Certifying Ph	rsician: To the best of my kno	owledne deat	h consumed at the fi	ma, data and clace	and duals than	review and marrier a	e status
	To the Hospital or Attent within 24 hours aftar deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examone)	iner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my o	pinion, death occu	rred at the time, o	date and place, and du	e to the cause(s)
	To th withir To th comp	ž	29b. Signature and title of certifier			29c. Licens		2	29d. Date signed (Mon	th, Day, Year)
			& Am	fing 1	MID.	DY	12821		5/30/	06
	3		30. Name an address on who co	completed cause of death (Iter			2	7		
			31. Date filed (Month, Day, Year)	32. Registrar's Signa	arure	nounte	ain Kd	· Pasa	odera o	21120
	Sta Registr			2006	M. A.	park				

				For State Registrar	State of M	Marylan		artment of rtificate o		d Mental Hy	giene Reg. No.	2006	16798
•		Physici /Medic Examir	cal	Decedent's Name (First, Middle, L Betty Ann Burke 4a. Facility Name (If not institution, g	2	or)		4b. City, Tow	n, or Location of D	2. Date of Do Month May 2 eath	3, 20	Year 06 County of Deat	3. Time of Death 10:28A ^M
1		Funeral Director		Upper Chesapeak 5. Social Security Number 6. 226-36-2799 Usual Residence of Decedent			ኒ last birthday) Yrs.	Bel in the second secon	sar If Under 24 h	Ars. 8. Date of Bi (Month, Da Jan 16	rth ay, Year)	Co	hplace (State or Foreign untry) VA
		Be-f ehow	ector	10a. State 10b. County Harford	d	10c. Cit	y, Town or Lo oppa						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
		after deeth with the Marylan or Itame 23a or 28e-f show of or mast be notified at	Funeral Director	10e. Street and Number 616 Harbonside 1	12. Was Deceder	nt Ever in U.	S. 13.1	10f. Zip Cod	21085	(Specify Yes or No		en of What Co USA 4. Race - Ame	
an	9800	nours after d ural', or Itan	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 Yes 27 If Yes, Give X Year or Date:	s? ZNo		1□Yes 2√X	No Specify:	(Specify Yes or No Jerto Rican, etc.)	5	Black, White	a, etc. Vhite
028	21215-0036	filed within 72 hours after deeth with the Maryland Hygiene. utter than "natural", or Itame 23a or 28e-f ehow ant. The Medical Executed fortified at	Completed	15. Decedent's (Specify only highest g	rade completed) College (1-4c	or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use re MEMARET	ne during most of tired)		Ow	n Home	Industry
0	Maryland	2 should be filed and Mental Hygi le marked other eumatic event.	To Be (17. Father's Name (First, Middle, Las Archie Edward Sc 19a. Informant's Name/Relationship	rott		10b Madie	an Address /Ctm	Mamie	Name (First, Middle Maine Sc Rural Route Numb	hnell	ings	To Code)
30/50/	altimore, Ma	l and lealth im 27 lher ti	I HE	James R. Burke 20a. Method of Disposition XIXIBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	□Removal from Sta	1 0	616 I	Harbors	ide Dr.,	Apt B, J Date 3 27, 200	oppa,	MD 210 ation - City or) 85-4475 Town, State
5	Balti	permit. Pages 'Department of P Important: If ite eny injury or of		21. Signature Fineral Service Lio K.* Gregory F	inste MO1	148				Glen ^A Bur		MD 2106	51
		Physician /Medical		23a. Part 1. Poter the disease or co shock, of heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a		Dire	er the mode of a		diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
12385	8760,	Examined be executed by sicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b	ESS IS	uence of):	Arusion	MOPATI HUNC	fy			
MSOOS	.O. Box 6	e death certifii he ettending p ied for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	death 3	Ectopic pregna Other (specify,			23	d. Date of deli- Month	very Day Year
N	ords, P	w requires that the been signed by the should be detach	by	Part II. Other significant conditions	contributing to death	but not resu	ulting in the ur	nderlying cause	given in Part I.	23e. Did t			the cause of death?
4 An	dal Record		e Completed	25. Was case referred to medical	- R					1 ☐ Yes	psy ormed? 20-No	prior to c death?	lopsy findings available ompletion of cause of
Beth	ion of Vii	Attending Physician: or death. ector: After this certific by the funeral director,	ToB	examiner? 1 Yes SONo 27 Manner of Death Yes address 2 Accident investigati			ER/Outpatien 28b. Time of Injury	28c. Ir	Othor	Death Check only of the graph o	dence 6		ify)
Burke	Division	ospitel or Atte hours after de uneral Directo y filled in by th	Certification:	3 Suicide 6 Could not determine	d 286. Place of I building,	etc. (<i>Specif</i> y	/)	eet, factory, office		City or To	wn, State)		ral Route Number,
8		To the Hospitel or Ai within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 2 Nedical Extended to certifier	hysician: To the beaminer: On the basis and manner	or examinat	wledge, death tion and/or inv	vestigation, in m	a time, date and pla by opinion, death of ense number	ace, and due to the ccurred at the time,	date and p	nd manner as lace, and due signed (Month	to the cause(s)
		.\		30. Name and address of person who	o completed cause of	f death (Item	23a) (Type,		2284	}	my	24	2006
		Sta Registr		31. Date liled (Month, Day, Year) MAY 3 0 20		strar's Signar		ORING.	M	Forest H	ıll	im 2	LIVIO

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** ONAL BROWN 2006 6, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner REHABILITATION EXTENDED CARE BALTI MORE BALTIMORE Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Mir **1**€M 2□ F Yrs. 219-03-0666 Director 86 May 18,1920 Maryland Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits in then "natural", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1. Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3838 Roland Avenue Apt 503 21211 USA deeth Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status o filed within 72 hours after dail Hygiene.

Other then "natural", or item Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: SpecifWhite þ 3√Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Air Conditioning and Elementary/Secondary (0-12) College (1-4or 5+) Refrigeration Parts Salesperson 11 Pages 1 and 2 should be filed and tent of Health and Mental Hygis ant: If item 27 is marked other? other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Bernard Brown Maud Irene Flater ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Anderson Step Daughter 1104 West 43rd Street Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State ö permit. Page Department of Important: If eny injury or once. Druid Ridge Cemetery 5/31/06 Pikesville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signal of Funeral Service Lig ^{22. Name and Address of Facility} Burgee—Henss—Seitz Funeral Home, Inc 3631 Falls Road Baltimore, Maryland 21211 Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG CANCER WITH METASTASIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Re Mar's Signature State Registrar 0

1 - For State Regis	strar	Sta	ate of N	Marylan	d / Depa <i>Cei</i>	artment <i>rtificate</i>				ental F	lygier Reg. I	200	36	16800
1. Decede	nt's Name (First, Middi	e, Last)								2. Date of Month	(Day	Year	3. Time of Death
edical Joa	n Beaver	n give street a	and numbe	r)		4b. City, To	own, or	Location of	of Death	May 2		2006 4c. County	of Death	8:15 A M
IIIICI	nberry Cot				ing		ltim					N/A		
	Security Number 32-5974	6. Sex 1 ☐ M 2			last birthday) 0 Yrs.	If Under 1 Months	Year Days	if Under Hours	24 Hrs. Min.	8. Date of (Month, May	Birth Day, Yea	ar) 1936		lace (State or Foreigr try) ryland
Usual Res	idence of Decedent 10b. County			10c. Cit	y, Town or Lo	cation							1	0d. Inside City Limits
Mary ق	land N/A				Baltin	nore								1 ☐¥es 2 ☐ No
10e. Stree	ot and Number O Spence S	t. Apt	120)	•	10f. Zip C	230				_	Citizen of W JSA	Vhat Coun	itry?
	I Status ever Married 2 ☐ Mar idowed 4 ☑ Divorced	ried 1 [as Deceder med Forces Yes 2 2 Yes, Give ear or Dates	Νo		Was Decede If Yes, specif	fy Cubar	spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto F	cify Yes or Rican, etc.)	No-		k, White,	an Indian, etc. ite
ieted	15. Deceder (Specify only higher tary/Secondary (0-12)		pleted) bliege (1-40	r 5+)	(Give	dent's Usual kind of work DO NOT use	Occupa done di retired)	tion uring mos	t of workin	ng	16b.	. Kind of Bu		dustry
	8 's Name (First, Middle,	(act)			Home	emaker		19 Moths	rte Name	/Circt Midd	do Maio	Own H		
Ď,	ster Lee D									na Hof			θ)	
	mant's Name/Relations		rint)		19b. Mailir	ng Address (Street a	nd Numbe	er or Rurai	Route Nur	nber, Cit	y or Town,	State, Zip	Code)
20a. Meth	ra Scott, od of Disposition Burial 2 Cremation	3 Remova			4113 Place of Disponentery, crest adowric	natory or oth	e of	9)	Da	Lar 05-31	20c.	vne, M Location - Lans	City or To	21227 wn, State
	onation 5 Other (Sture of Euneral Service		> .		22	27150								esta la race
Sequenti if any, leac cause. E Cause (D that initia	e Cause (Final or condition in death) ally list conditions, using to immediate inter Underlying isease or injury ed events in death) Last	b	Due to (or a	as a consequate a consequence a consequate a consequate a consequate a consequence a consequence a consequence a consequence a consequence a consequence a consequence a consequence a consequence a consequence a consequence a consequence a consequence a consequence a consequence a consequence a consequence a consequence a consequence a conseq	uence Jij.	uisi	10	heri	hees	y a	b fr	a st		Onset and Death Stylia
IF FEMAI 23b. Was in th	E: decedent pregnant e past 12 months? Yes 2 ☑ No Unknown	1 C 4 C	Live birth	ne of pregna 2 □ Feta at time of d	Ideath 3	Ectopic pred Other (spec						23d. Date Mor	e of delive	ry Day Year
A	her significant conditi	ons contributi	ing to death	but not res	ulting in the u	nderlying cau	use give	n in Part I.					ibute to th 3 ☐ Prob	e cause of death?
Completed										24a. W au pe 1 Yes	topsy rformed:	? P	rior to con leath?	osy findings available npletion of cause of
m exam		l Hospita	al:		50/0		Othe			(Check onl			a	its to
F	er of Death atural 5 Pendi		a. Date of Ir		28b. Time of Injury		c. Injury Work	at ? ′es 2□	2	ne 5□Re 8d. Describ		6 Othe		aving
3 □ 3	Guicide 6 Could determined		e. Place of I building,	Injury - At he etc. <i>(Specif</i>	ome, farm, str	reet, factory,	office		2		n (Street Town, St		er or Rura	l Route Number,
7 29a. Cerl	ck only 2 Medical	ng Physician: Examiner: O ar	n the basis	of examina	tion and/or in	vestigation, in	n my op	inion, dea	th occurre	d at the tim	e, date a	and place, a	and due to	the cause(s)
	ature and title of certific	7	1	/,	11	29c.	License	number	7101	,	29d. [Date signed	(Month, I	Day, Year)
	///			1	w	/ X	01	61	76	7	ne	14,	26,	1006
30. Name	and address of person	complete	ed cause of	f death (Item	n 23a) (Type,	Print)	ho	ile.	len	e B	Ol	fu	10	21228
State 31. Date	na I pr filed (Month, Day, Year	/K	7 20 32. Regis	Strar's Signa	ature	enc	w		ve p					Day, Year) , 2006 2122 J

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day **Physician** Richard Waterman Bandel, Sr. May 26 2006 2:30 am /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 4310 Belmar Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 72 Yrs. 219-28-2959 Director July 20, 1933 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Heath and Mental Hyglene. In the Maryland show shir! If item 27 is marked other then "natural", or items 23a or 28a-f show my or other traumatic event, "I've Medical Exercities in the notified at my or other traumatic event, "I've Medical Exercities in the notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Director MD n/a Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4310 Belmar Avenue 21206 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🗱 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Welder Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Harmon Bandel Nellie Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Carolyn Bandel/Wife 4310 Belmar Avenue, Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any njury or once. 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley May 30, 2006 Timonium, MD 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6415 Belair Road, Baltimore, MD 21206 23a. Part . Enter the disease, or complications shock or heart failure. List only one caust t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Carcinoma Bladder **Examiner** ransitional Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury Examiner Due to (or as a consequence of): Carcinoma Ureter burial-transit The law requires that the death certificate be executed ITUMSI HOME that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, attending physician by Physician/Medical as the l IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy ŏ in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. the detached 9□ Unknown 9 Unknown þ signed Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þe 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No 10 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 Nursing Home 5 → nce 6 Other (Specify) 0 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and ti 29c. License number 29d. Date signed (Month, Day, Year) completed cause of leath (Item 23a) (Type, Print) 6 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar MAY 3 0 2006 DHMH 17 Rev 1/2001

ORIGINAL

		_ For	Type or Print in E State of Marylan	nd / Departme	nt of H	lealth and I	-		_	16802
		1 - State Registrar		Certifica	ite of	Death		Reg. No.		, , , , , , , ,
		1. Decedent's Name (First, Middle, Last,					2. Date of De	eath Day	y Year	3. Time of Death
Physic /Med		Charles A. Bar	nett				May	27		935 PM
Exami		4a. Facility Name (If not institution, give	street and number)		, .	or Location of Death	h .	4c.	County of Deat	h
		Sinai Hospital of	Baltimore		altim				n/a	
Funera	1	5. Social Security Number 6. Se:	x 7. Age (In yrs.	Month	er 1 Year s Days		8. Date of Bi (Month, D	av, Year)	Co	hplace (State or Foreign untry)
Director	r	213-68-8169	50	Yrs.			May 5	, 19	56 So.	<u>Carolina</u>
pu *		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	tv. Town or Location						10d. Inside City Limits
aryla sho	5			D = 1 + 1 - 0 m c						1⊠Yes 2□No
he N 28e-f	Director	Md n/a		Baltimore	Zip Code			10g Citi	izen of What Co	untry?
with B or	늅	5906 Park Heig	Thto Asso A			215			USA	,
e 23	Funeral	11. Marital Status	12. Was Decedent Ever in U				pecify Yes or N	0-	14. Race - Ame	nican Indian,
iter d	S	1 Never Married 2 Married	Armed Forces? 1 Yes 2 27No	If Yes, sp	ecify Cub	Hispanic Origin? (S an, Mexican, Puert	o Rican, etc.)		Black, Whit	e, etc.
is at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 X No	Specify:			Specify:	√hite
the true	Pe	15. Decedent's Edu	cation	16a. Decedent's Us	ual Occup	pation	4.:	16b. K	ind of Business	Industry
Mad I	Completed	(Specify only highest grad	College (1-4or 5+)	life. DO NOT	use retire	during most of world)	rking			
d with	E	8	0	Maintena	ance	Mechan	ic	Apa	ertment	Complex
of Hy die	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar		e, Maiden	Sumame)	
Menta Menta itice	10	Charles M. Barr	nett			Nancy	Сох			
ite, IVIDITYIDITULE INTENDED ON STATE OF THE Manyland is 1 and 2 should be filed within 72 hours after death with the Manyland if Heelih and Mental Hygiene. Item 27 is marked other then "neturel", or iteme 23e or 28e-1 show other treumstic event, the Madical Examinar must be notified at	1	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Addre						
end in 27 m 27 m 27 m 27 m 27		Mr. Curtis Bar		7247 Br		wood Dr				
Tite of the contract of the co		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F	Damayal from State	Place of Disposition (A cemetery, crematory o	r other pla		Date		ocation - City or	
Pages ment of I		4 □ Donation 5 □ Other (Specify)	Oa.	k Lawn Ce					timore	e, Md.
Dallingle, IV. pernit. Pages 1 end 2 Depertment of Heelth 3 Important: if item 27 is any injury or other tre	į	21. Signature of Funeral Service Licens	ee P	11		skffaciffun				
40 = 40	N .	Cagere)	(cotton			<u>dalk Av</u>			ore, Mo	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the dea ne cause on each line.	ty. Do not enter the m	ode of dyi	ing, such as cardiac	c or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician	1	tmmediate Cause (Final disease or condition	. Stroke							4 days
/ /Medica Examine		resulting in death)	Due to (or as a consec	quence of):						1
Examine		Sequentially list conditions,	b							
ad sit	Examiner	tany leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence or):						
BOX 507 500, eath certificate be executed ettending physicien end for use as the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):					_	
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. DOX OO! OU death certificate be e ettending physicie of for use as the bu	Physician/Medica	IF FEMALE:	23c. If yes, outcome of pregn	ancy					23d. Date of de	livery
etter for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of			У			Month	Day Year
the dy the check	İsk	9 Unknown	9 Unknown							
thet	by Pi	Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlying	g cause gr	ven in Part I.	23e. Did	tobacco i	use contribute to	the cause of death?
duires		Hupertension					1 🗆	Yes 2	□No 3□P	robably 4 Unknown
w req	Completed	11					24a. Wa		24b. Were a	utopsy findings available
he la	E G						peri	opsy formed?	death?	completion of cause of
VITAL ician: T certificat rector, pa	ပိ	25. Was case referred to medical				26. Place of De	1 ☐ Yes	2 (28)No	1 □ Yes	202/110
vsicie s cert direct	To B	avaminor?	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Ot	har	dome 5 ☐ Res		6 ☐Other (Spe	cify)
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of full After	at o	1 Natural 5 Pending 2 Accident investigation		Injury M		Yes 2 No				
LIVISION I or Attending effer death. Director: Affe	150	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, street, fact	ory, office			(Street ar		ural Route Number,
S effect	Certification:	- I nominate	Danding, etc. (Spec				5, 5	, Juli		
LIVISION OF VITAL RECORDS, P.O. To the Hospital or Attending Physicien: The law requires thet the de within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.			ysician: To the best of my kn	owledge, death occurr	ed at the t	ime, date and place	e, and due to the	e cause(s) and manner a	s stated.
he H in 24 he Fi pletel	edical	one)	and manner stated.				une une une			
To t Withi To t	Σ	29b. Signature and title of certifier		:		se number			ite signed (Moni	h, Day, Year)
4		1 (gaz w	DO DO			5-000		Mai	1 27,3	2006
10		30. Name and address of person who o			1	- Baltim				
<u> </u>		Carolyn Wan		nui Hospita	c) of	- baltim	1016			
Regis	State strar	31. Date filed (Month, Day, Year) MAY 3 0 2	32. Aegistrar's Sign	lature Agent	9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#20a-c,perFH,C855,5/30/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) COLUNS **Physician** 18:06 MAN 7000 HOMAS /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) Examiner HOSpita N/A Tunder 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year)
DEC 26 1947 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 € M 2 □ F 283-48-2067 58 Connecticut Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at 1 Yes 2 Xio by Funeral Director VA Fairfax Vienna 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9900 Timmark Court 22181 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Writing Public Affairs other it of Health and Mental Hyg If Item 27 is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Executive Pages 1 and 2 should be Robert Thomas Collins Mary Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9900 Timmark Court Vienna VA 22181 Sun Oak Collins spouse Baltimore, 20c. Location - City or Town, State
Cronwell
Berlin CT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 1 Sorial 2 Cremation 3 Removal from Department of Important: If any injury or once. 2006 May lcox Cemetery Pecticut Valley Cemetery * 4 ☐ Donation — 5 ☐ Other (Specify) 21. Signature of Fineral 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122 au ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and line. 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PHEUMONIA 10 Physician /Medical Due to (or as a consequence of) DAYS **Examiner** BACTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs [Discuss or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine WRENK MYLOMONOCYTE LEWKENNA and all-transit or Attending Physician: The law requires that the death certificate be executed FEMIS Due to (or as a consequence of) burialsicien Box 68760. Physician/Medical the phys the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown ģ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 10 3 Probably 4 Unknown should by Be Completed 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an has b autopsy page performed 1 Yes 21 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No 1 Impatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAY 24, 2006 1268-000 - MEDICAL DOCTOR W 03A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPLUMS HOSPITAL, GOD NOWTH WOLFE STREET, BALAMONE, MANYLAND 21287 KEVIN WODDS THE 31. Date filed (Month, Pay State Registrar

			1 - For State Registrar	State of M	1arylar		artmen rtificate			ınd M		Reg	ne No2006	16804
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Las Harlan Andrew Cha Harlan Andrew Cha Facility Name (If not institution, give	dw	r)		4b. City,	Town, or	Location o	f Death	2. Date Monti	of Death	Day Yea 2006	12:45 PM
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	Director Mode	o.r	234 46 6786 15 Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor			ty, Town or Lo	cation				Aug.	22,19	930 Wes	st Virginia 10d. Inside City Limits 1 □ Yes 2♥ No
	ath with the N 23a or 28a-f	rai Directo	10e. Street and Number 618 Dorsey Avenue		1		10f. Zip	212					. Citizen of What (
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ıryland	2 should be tilt and Mental Hy is marked oth sumatic event	To Be	17. Father's Name (First, Middle, Last) Andrew Jackson Cha 19a. Informant's Name/Relationship (T)			19b. Mailin	ng Address		Ethe	1 A	lt		iden Surname) ity or Town, State	. Zip Code)
Baltimore, Maryland 21215-0036			Geneva G. Champ (W 20a. Method of Disposition 1 \(\mathbb{X}\)Burial 2 \(\mathbb{C}\) Cremation 3 \(\mathbb{I}\) 4 \(\mathbb{D}\) Donation 5 \(\mathbb{O}\) Other (Specify,	Removal from State	a (618 I	Dorse	Y AVE	enue :	Balt	imore	e, Ma	aryland 2	21221
Baltir	permit. Page Department of Important: If any Injury or		21. Signature of Funeral Service Licens	11. 3.5	^	B1	Name and	Addres	of Facility	eral	. Home	e P.A	A. Maryi	Land 21221
8760,	law requires that the death certificate be executed as been signed by the ettending physicien and 2 should be detached for use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, of compositions shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to ammodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	s a consequence	addle quence of):	er the mode	a of dying	ulr	eardiac d	or respirato	ory arrest,		Approximate Interval Between Onset and Death
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Division of Vi	tending Physici leath. tor: After this cer the funeral direc	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	1 □ Inpat 28a. Date of Inj (Month, Da	ury ay Year)	ER/Outpatient 28b. Time of Injury	M 28	Cther Ct	. 4 Nur	sing Hon	ne Sis 28d. Desci	esidence ribe how i	njury occurred	lesidence ediy)
Divi	To the Hospital or Attend within 24 hours etter death To the Funeral Director: completely filled in by the t		4 ☐ Homicide determined 29a. Certifier 1X Certifying Phy	mician: To the best	tc. (Specif	(y) wiledon denth	occurred a	et tha time	a date and	claes s	City o	tha caus	tate)	Rural Route Number,
	To the Ho within 24 h To the Fu	Medical	29b. Signature and title of certifier	ner: On the basis and manner s	of examina	ation and/or inv	estigation,	License	nion, death	1 occurre	ed at the ti	me, date	Date signed (Mon	e to the cause(s)
	17		30. Name and address of person who co	alma A	d.	Sute	Print) 08		Bal	4.	Md.	21	237	1
	Sta Reg istr		MAY 3 0 26		rar's Signa	K A	red	,						

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TIEM# 7 PIR F. H. (356 / 1-06 W) of Health and Mental Hygiene 2 0 0 6

Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey Month ,00 Physician CALVIN JOHNSON CLARK, JR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number, Examiner ROSECOLE
If Under 24 Hrs. 8. Date o 1ti MORE Garage 7. Age (In yrs. last birthday) tranklin Birthplace (State or Foreign Country) If Under 1 Year Months Days 8. Date of Birth OCL 9, 1917 5. Social Security Number **Funeral** Hours Months **№** M 2□ F 88 217-09-5905 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryler Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at Baltimore MD Baltimore 1 ☐ Yes 2√2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21220 USA 1502 Burke Road 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No 1 Never Married 2 Merried White 1 ☐ Yes 2 ZNo Specify: Specify: þ 3 ☐Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Martin Marietta Company Model Maker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Mamie Margaret Gardner Calvin J. Clark, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9004 Chateaugay Court-Baltimore, Maryland 21234 Helen Evans-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Moreland Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition 5-27-06 Parkville, Maryland 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Fecility EVANS CHAPEL OF MEMORIES 8800 Harford Road-Parkville, MD 21234 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or commendations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical MRSA SEPIS Examiner Medical Certification: To Be Completed by Physician/Medical Examiner Septic arthritis To the Hospital or Attending Physician: The law requires that the death certificate be executed use es the buriel-trensit Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2X No 3 Probably 4 Unknown per tension 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? certificate hes 1 ☐ Yes 2 No 1 ☐ Yes 2√2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tyes this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 X Natural 5 Pending i Director: Aft of in by the fur 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours of To the Funerei 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. completely (Check only 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of certifier 150 30. Name end address of person who completed ceuse of death (Item 23e) (Type, Print) Franklin Spiare de Baltimore, HD 21237 Be 9000 nadEREL 1 OVA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Le gerer Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) రి2006 MAY 26, Physician CAPLAN DAVID 1:18 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL BALTIMORE N/A Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Date of Birth **Funeral** Days 02718/1923 1 M 2 □ F Months Hours Min 83 MD 217-12-6570 Director Usual Residence of Decedent Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Iteme 23a or 28a-1 ahow the Medical Examinational be notified at 1 ☐ Yes 2 ▼ No Director MD BALTIMORE BALTIMORE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 POMONA EAST #205 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: WHITE 2 Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "na any lojury or other traumatic avent, the Medic one. Elementary/Secondary (0-12) College (1-4or 5+) TAILOR SALESMAN CLOTHING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CAPLAN LEVIN THOMAS LILLIAN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 POMONA EAST #205 - BALTIMORE, MD 21208 ANITA CAPLAN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CEMETERY 05/28/2006 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DIFFICILE COLITIS LOSTRIDIUM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed DementiA Division of Vital Records, P.O. Box 68760 PERTENSION Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unimown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death | Check only one examiner Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient - Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending after death. I Director: Aft d in by the fun 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 0 MAY 279 2006 ad, columbia Spuple MO 00053 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Santi MD 21045 State MAY 3 0 2006 Registrar

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	1	_			,60	Certi	ficate of	Death			0 10007
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1	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	1 71		4b. City, Town,	or Location of De		4c. County of De	
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	Funeral		5. Social Security Number 6. Security Number 217–16–5768	מאן ארב	(In yrs. Ia 90		If Under 1 Year Months Days		in. 8. Date of Bir (Month, Da 3-30-	th 9. 8 V. Year) MA	irthplace (State or Foreign Country) RYLAND
	Director		Usual Residence of Decedent							1,10	
	anylan show	_	10a. State 10b. County		•	Town or Loca					10d. Inside City Limits 1 Yes 2 No
	the Ma	ecto	MD N/A		BA	LTIMOR	E 10f. Zip Code			10g. Citizen of What	
	3a or	Funeral Director	722 DOLPHIN ST.				2121	7		USA	
	ams 2	Iner	11. Marital Status	12. Was Decedent E Armed Forces?		. 13. Wa	as Decedent of res, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Race - Ar Black, Wi	nerican Indian, nite, etc.
36	hours atter death with the Maryland turst', or Itams 23a or 28a-f show at Examinational be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	0	10	Yes 2∏ No	Specify:		Specify:	BLACK
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d 2	a filed v Il Hygie othar t		-8- 17. Father's Name (First, Middle, Last)	-0-		поозе	REEFING		Name (First, Middle,		.10
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Maryland 21215-0036	2 should and Men is marks rsumatic		19a. Informant's Name/Relationship (7	ype, Print)		100000000000				er, City or Town, State	
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Baltimore,	permit. Page Depertment of Importent: If any Injury or once.		21. Signature 41 mral Service Licen	see JONATHAN	D. I						
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of	Physical distribution	ا: T	1 Yes 2 2 No 27. Manner of Death	28a. Date of fnjur	y	R/Outpatient 28b. Time of	28c. Inju	4 🗆 Nursin		dence 6 Other (S)	Decity)
ion	Attending I or death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident Investigation		rear)	Injury		Yes 2 No			
Division	5 # 5 E	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At hor . (Specify)	ne, farm, stree	et, factory, office		281. Location (City or To	Street and Number or wn, State)	Rural Route Number,
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			30Name and address of person who	JUM HO	SPIT	23a) (Type, P			^		1/ 1 1
_			Christine Kai	ubi 540	10	ld Co	urtk	load 1	Randal	Istown	Maryland
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		1	For State Registrar				land / De		t of H	ealth a	and N	lental Hy	/gienę Reg. No.	711115	168	308
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9	/Medica Examine	er	Gilchrist	t Hospi				Balt	imor				Ва	County of Dea		
	Funeral Director		5. Social Security N 216-34-40	090	6. Sex 1 ☐ M 2 ☐ F		yrs. last birthda	Months	Days	If Under Hours	Min.	8. Date of Bi (Month, Di Nov • 2	0, 1	9. Bi 937 Mar	thplace (State ountry) 'yland	or Foreign
	Aaryland I show		Usual Residence o 10a. State MD	10b. County Baltime	ore		c. City, Town or	Location							10d. Inside C	City Limits
	with the Associated as or 28s-	Direct	10e. Street and Nu	mber			,	10f. Zip						zen of What C	ountry?	
36	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Event or ermusite to the property of the propert	Funer	4603 Pros 11. Marital Status 1 □ Never Marr 35€Widowed	ied 2∐ Marri	12. Was Dec Armed Fo	orces? 2x∏xNo ve	r in U.S. 1	210 3. Was Deced If Yes, specific Yes	lent of Hi cify Cuba			ecify Yes or N Rican, etc.)		14. Race - Am Black, Wh Specify: Wh	te, etc.	
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			For State of Maryland / Department 1 - State State of Maryland / Department Certificate			2011	16809
			1. Decedent's Name (First, Middle, Last)	or Death	2. Date of Deatl	eg. No.🖘 🔾 🔾 🔾	3. Time of Death
	Physici	an			Month	Day Year	1 300.
	/Medic		Kathareen A. Doebereiner 4a. Facility Name (If not institution, give street and number) 4b. City, To	own, or Location of Death	<u> </u>	4c. County of Dea	
	Examin	er	Ja Win Garage Hospiel Da	SENALE			nolf
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Year If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign ountry)
	Director		217-14-9426 1□ M 2∏F 85 Yrs. Months	Days Hours Min.	(Month, Day, Nov. 22		ountry) Maryland
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36 7	s afte	by Funerai	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2 ☒ Widowed 4 □ Divorced Year or Dates:	No Specify:		Specify: Wh	nite
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in 5			20a. Method of Disposition 20b. Place of Disposition (Name cemetery, crematory or oth	er place)	Date 2	20c. Location - City or	Town, State
DO E	Pages nent of ant: If it ary or o		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 3 □ Other (Specify) Hilltop Serv.	Corp. 5/27	/2006	Towson, Ma	ryland
(-)#	permit. Page Department of important: if any injury or once.		21. Signature of Ameral S. vice Litensee	Address of Facility Ruck Funeral	Home of	Dundalk	Inc
ω	89889			Nise Avenue			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.	of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
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<u> </u>	w requires theles been signed to should be detailed.	Pa Da			1 □ Ye	s 2.12 No 3.∏Pr	robably 4 Unknown
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0	ng Pt Iter († neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of lnjury	c. Injury at Work?	28d. Describe ho	w injury occurred	
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	To the Hospitel or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use a	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at control of examination and/or investigation, is and manner stated.	n my opinion, death occur	and due to the ca red at the time, da	iuse(s) and manner as ate and place, and due	stated. to the cause(s)
	o the	Me		License number	29	9d. Date signed (Mont	h, Day, Year)
	⊢ \$ ⊢ ō			061.271.1		K-2U-	-1710
	•		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	000010		5-44	-06 ee md 21201
	10		DR. MUHamed Jassin 821 N. EU	taw St. 5	Suite 30	08 Rathma	REMD DIADI
	Sta	ate	31. Date filed (Month, Day, Year) 22. Registrar's Signature			4 1 111/10	7
¥	Regist	rar	MAY 3 0 2006 Medica & Sparker				

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland 7 Department of Heath and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 26, Day 2006 **Physician** DAVIDOV ELSIE ZERWITZ 5:05 A M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE N/A 7218 PARK HEIGHTS AVENUE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 12/03/1910 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 😿 F MD 95 220-09-3931 Yrs Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itsms 23a or 28a-1 shov the Medical Examiner must be notified at N/A BALTIMORE 1 X Yes 2 □ No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA 7218 PARK HEIGHTS AVENUE Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or its any injury or other traumatic event. the Modical Examinat 1 Never Married 2 Married WHITE altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MEDICINE OFFICE MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHAYA TDA FRIEDMAN ZERWITZ SAUL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7221 DENBERG ROAD - BALTIMORE, MD 21209 HOWARD DAVIDOV / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State SHAAREI TFILOH CEMETERY 5/28/06 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final aca Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispuse or injury) nce of Examine ng physician and as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ √0 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 2 No 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2000 certificate 1 Yes 1 Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 Other: ۵ 4 Nursing Home 5 Residence 6 Other (Specify) this Director: After this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatura and title of certifier who completed cause of 30. Name and address of person Greene SER 32. Registrar's Signat 31. Date filed (Month, Day, Year) State 012006 Registrar DHMH 17 Rev 1/2001

ORIGINAL

		1_ State	partment of Health and Me ertificate of Death	_	ne 2006-16811
		Registrar 1. Decedent's Name (First, Middle, Last)		. Date of Death	3. Time of Death
Physic		Myrtle Estelle Elza			2006 8:25 pm ^M
/Med Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May 20,	4c. County of Death
LXdiii	ilici	Riverview Care Center	Essex		Baltimore
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
Directo		219–16–6339 1 M XV F 81 Yrs.	33,0	7/24/192	24 Maryland
pus *	7	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	_ocation		10d. Inside City Limits
faryld r sho	ŏ		,		1 ☐ Yes 2 💯 No
the N	Director	Maryland Baltimore Middle F	10f. Zip Code	10g.	Citizen of What Country?
3a or	0	7301 Tredavon Road	21220	7.1	J. S .A.
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nit. F artme ortar injur	i	21 Signature of Funeral Service Licensee	22. Name and Address of Facility		•
permit. Departr Importa		Rechard C. Falfras, Sr.	Bruzdzinski Funeral 407 Old Eastern Ave	Home PA nue Ess	ex. Maryland 21221
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ore			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	on (Name of ory or other place)	20c. Location - City or Town, State
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	0		Danne Jan	038563	may 26,2006
ì	70		30. Name and address of person who completed cause of death (Item 23a) (Type, Pzi	ing On 1	may 26,2006
-	~		Wayne Bicrbaum 134 avensus	MO MY WEST O	FIVOL VAL
	St Regist	ate [®] rar	31. Date filed (Month, Day, Year) MAY 3 0 2006 32. Registrar's Signature	nesti)	
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Examin	er	4a. Facility Name (If not institution Montgomery Gene	-			01ne		Location	OI Dealli			ontgome			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Birt	h	9. Bi	irthplace	(State or Fo	reign
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pur *	}	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d.	Inside City Li	mits
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If Item 27 is marked other then "natural", or items 23a or 28a-f show any nury or other traumatic event, Ite Medical Examinar must be notified at once.	Funeral Director	24201 Laytonsv	ille Road			208	82				USA		_	<u>.</u>	
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nark	2	19a. Informant's Name/Relations			19b. Mailie	ng Address	(Street a	and Numb	er or Rura	l Route Numbe	er, City o	r Town, State,	Zip Co	de)	
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DO Jeath atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 \(\subsection \text{Yes} 2 \subsection \text{XNo} \)	4☐Preg	birth 2 ☐ Feta mant at time of c		□Ectopic po □ Other (sp						Month	Da	y Year	
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DIVISION I or Attending after death. Director: After tin by the fune	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inad 286. Plac	e of Injury - At h	ome, farm, st	reet, factor	y, office		4	28f. Location (. City or To			Rural R	oute Number,	
Urs aft	Cer														
To the Hospital or Attanding Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	licai	(Check only 2 Medical one)	examiner: On the	basis of examina basis of examina nner stated.	wiedge, deal ation and/or in	n occurred ivestigation	, in my o	na, date a pinion, de	ath occurre	and due to the ed at the time,	date and	place, and di	ue to the	d e cause(s)	
o the o the omple	Med	29b. Signature and title of certifie		iner states.		29	c. Licens	e number			29d. Da	te signed (Moi	nth, Day	v, Year)	
- s - o		Bervett	Morn		M	D	4768	2		N	lay 2	22, 200)6		
200		30. Name and address of person			11 23a) (Type,	Print)							-	7.	
· V		Bennett Morris	TI ONE WAY				Spri	ng Ro	1. 01	ney, MI	208	332			
	ate	31. Date filed (Month, Day, Year,	2000	Registrar's Sign	ature	Ke)									
Regist	rair	MAY 3 0	ZUUb Me	Lesson J.S.	ASSAU										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 26-Day 2006 Year **Physician** MAY 4:17 A. M MILDRED VIRGINIA FELTS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TAWES NURSING HOME BYRD CRISFIELD SOMERSET 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Pay 1974) 8. Days Hours Min. 0970671914 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1□M XXF 213-36-7642 MARYLAND Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at SOMERSET STATION MD. MARION 1 Yes 2XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28143 CRISFIELD MARION ROAD 21838 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2000 If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or iten any injury or other traumatic event, tra Madical Examinar once. 1 Never Married 2 Married 1 ☐ Yes 🏋 No WHITE δ Specify. XX Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Efementary/Secondary (0-12) College (1-4or 5+) YEARS HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GEORGE CALVIN Ε. ZEPP FITZE JENNY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM THOMAS FELTS, JR. (SON) 28143 CRISFIELD MARION ROAD, MARION STATION, MD. 21838 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition or other place 1) Burial 2 Cremation 3 Removal from State DULANÉY VALLEY M.G. 106-01-2006 TIMONIUM, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1050 YORK RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 1 📋 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗌 Yes 2 No 3 No or Attanding Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) No Hospital: Other: 4√ ursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending To the Hospital or Attandi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

Dr. Visay Karumbunathan

29b. Signature and title of certifier

32. Registrar's Signature

2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 4809C

Alice Byrd Nursing Home , Crisfield, Md. 21838

29d. Date signed (Month, Day, Year)

			1 - State Registrar	State of Ma	-	partment of ertificate o				giene Reg. No. 0 0	6 16815
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	Funeral Director			⋈ м 2□F	84 Yrs.	Months Day	rs Hours	Min.	12/05/19	ŽĮ ^{ear)} M	ary land
	Maryland	ctor	10a. State 10b. County N/A		10c. City, Town or Baltimore						10d. Inside City Limits 1 Yes 2 No
	h with the 23a or 28	Funeral Director	4516 Furley Ave.			10f. Zip Code 21	206			10g. Citizen of Wha U.S.A	t Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Depertment of Heelth and Mental Hygiene Importent: If item 27 is marked other then "natural", or iteme 23a or 28e-f show sayl fujury or other treumatic event, the Medical Evantian must be notified at Once.	þ	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Dayes 2 N If Yes, Give Year or Dates:	o WWII	3. Was Decedent of If Yes, specify Control of IX Yes 2□ N			cify Yes or No Rican, etc.)	Black, V	American Indian, Vhite, etc. hit e
Maryland 21215-0036	l within 72 ho liene. r then "natur the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12)		(G	cedent's Usual Occ ive kind of work don b. DO NOT use reti Foreman	cupation ne during mos ired)	st of workin	ng	16b. Kind of Busin Docks On	ess/Industry Sea and land
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	nd 2 should hith and N 27 is main r treumal		19a. Informant's Name/Relationship (Rose M. Fassio / Sist			ailing Address (Stre 16 Furley A			e, MD 21	er, City or Town, Sta	te, Zip Code)
Baltimore,	Pages 1 a nent of Hee ant: If item ury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif		20b. Place of Discemetery, of	sposition (Name of trematory or other pervice Corp	place)		ate	20c. Location - City Towson, M	
Balt	permit. Depertr Importe eny inju		21. Signature of Euneral Service Lice	Kimberly D	avidson	22. Name and Add			305 Harf altimore	ord Rd. , Maryland 2	21214
	Physician /Medical Examiner	ılner	23a. Part : Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as a	the death. Do not e	Prim	lying, such as	nan Fvo	Cy (probable olon	Approximate Interval Between Onset and Death
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စ်	s 1 and f Health itam 27 othar tr		20a. Method of Disposition	nephew)	20b. Place of Disc	osition (Name of	Di	1	20c. Location - City of	r Town, State
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Baltimore,	and and and and and and and and and and		21. Signature of Funeral Service Lice	nsee		22. Name and Addre	ess of Facility			
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			> MM	UND	DOW	R Res	5-000	(May 19	2006
į	i 1		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	Print)	1)	٠٥ - ١	,	2006 Mary w Muse 21287
	12		Matthew Baldwin	The Johns	Hapkins t	ospital, 6	00 NoFly Wo	He Str.	ect, Balt	more 2/287
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State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY 27, 2006 **Physician** FRIEDMAN 12:01 PM IDA SYLVIA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A BALTIMORE 7111 PARK HEIGHTS AVENUE #202 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 07/22/1920 Months Days Hours 1 □ M 2 🕅 F 217-16-4772 85 Yrs. MD Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 23a or 28e-f ehow Examiner must be notified at 1 Ves 2 □ No MD N/A BALTIMORE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7111 PARK HEIGHTS AVENUE #202 21208 death v Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or iteme 11. Marital Status 1 Yes 2 X No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify þ 3 Widowed 4 Divorced natural', Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **CLERK** CIRCUIT COURT or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Oppartment of Health and Mental Hy Importent: If Item 27 Ie marked oth eny injury or other traumatic event ODGE. Be **FAGAN** SARA CHENKIN ISAAC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRVING FRIEDMAN / HUSBAND 7111 PARK HEIGHTS AVE. #202 - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ARLINGTON CHIZUK AMUNO 5/29/2006 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Soluto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Int rval Between Ou et and Death Immediate Cause (Final **Physician** ONDES 12 CON disease or condition resulting in death) /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wonknown peed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 2 No certificate 1 Yes After this certification funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ esidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No .. death. investigation 2 Accident the within 24 hours after deatl To the Funerel Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 0 29a. Certifier Entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie address of person who completed cause of death (Item 23a) (Type, Print) egistrar's Signature 31. Date filed (Month, Day, Year) State 3 0 2006

DHMH 17 Rev 1/2001

Registrar

06-03510 Sean Griffin

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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Medical Examine		SEAN GRIFFIN				(5	May 24, 2		ty of Death	0/30 fils
	4	la Facility Name (if not institution, give Howard County Jail	street and number)	2	b. City, Town, or L Jessup, MD	ocation of Deal	.П	Howar	-	
	Ľ	5. Social Security Number 6. Se	7 Age (In vr	s. last birthday)	If Under 1 Year	If Under 24Hr	s. 8. Date of B	rth (MM/DD/YY	YY) 9 Birthpla	ace (State or
Funeral Director					Months Days		→	8/1968	Foreign /	ARYLAND
5,100,0		214-82-1397 XX	M 2 F 38	Yrs.	<u> </u>		1007			
su k		Oa State 10b. County	10c. C	ity, Town or Locati			_			d Inside City Limits
<u>&</u>		MD N/A		BALT	IMORE (CITY			1	Xyes 2 No
Maryland 28a-f show d at once.	Director	Oe. Street and Number			10f. Zip Code			10g Citizen of	What Country?	?
th the Maryland 23a or 28a-f sho notified at once		4506 KATHLANI) AVENUE		2120	/		USA		
ms 23	Funeral	11 Marital Status	12. Was Decedent Ever in Armed Forces?		s Decedent of Hisp es, specify Cuban,				ace - American hite, etc.	Indian, 8lack,
death or ite	<u> </u>	1 X Never Married 2 Married	1 Yes 2 X N	0			,		DTA	CK
s after ral",	ᇍ		If Yes, Give Year or Dates.		Yes 2 X No		work done	Specif	Business/Indu	
hour:	ed -	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	ost of working life.	DO NOT use re	tired)			
36 hin 72 thau dical	e l	12TH	g-(,	LAI	BORER			LABC	RER	
5-0036 led within 7 Hygiene I other thau the Medica	Completed	17. Father's Name (First, Middle, Last)			1		ne (First, Middle,			
21215-0036 Juld be filed within 72 hours af Mental Hygiene marked other than "natural" cevent, the Medical Examin	e B	TYRONE MCCAIN		0.000	000000000000000000000000000000000000000		LYN L.			
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23 or 28a-f shr injury or other traumatic event, the Medical Examiner must be notified at once	0	19a Informant's Name/Relationship (T	ype, Print) 로로도N / MO판단단		Address (Street KATHLA)	and Number or	Rural Route Nu	imber, City or T	own, State, Zip	1207
imore, MD 2 Pages and 2 shoul ment of Health and N tant: If item 27.	- 1	CAROLYN L. GRI		b. Place of Dispos			Date		on - City or Tov	
or He,		1 X Burial 2 Cremation 3	D	crematory or oth	ner place)		31/06		SOR M	
Page ment tant:		4 Donation 5 Other Specify				'	•			
Baltimore, permit Pages I at Department of Hes Important: If ite		21. Signature of Funeral Service Licen		- 1	lame and Address					E 21207 MORE,MD
Physician	-	Ba. Part I. Enter the disease, or comp f ilure. List only one cause on ea	lications that caused the de	eath. Do not enter t	ne mode of dying,	such as cardiac	or respiratory a	rrest, shock, or	heart /	Approximate Interval
/Medical	ľ		ch line. Hanging						;	Between Onset and Death
Examiner	ŀ	Lamediate Cause (Final disease a. or condition resulting in death)	Due to (or as a consequent	ce of).						
		Sequentially list conditions, b.								
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequent	ce of):						
	Examiner	(Liseasu or injury that initiated events resulting in death) Last	Due to (or as a consequent	ce of):						
executed an and al - transi		d.	-	-		·				
- o .2.E	/Medical	UNPENDED	AMENDED					The state of the s		
68760, certificate be anding physiciase as the buri	NA.	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of p		tal death 3	Ectopic preg	nancv	23d. Date Month	e of delivery h Day	Year
certif		past 12 months?	4 Pregnant at time of	£	ther (Specify)		,,,			
Box 68760, e death certificate be the attending physic ed for use as the burner of the burner as the	Physicia	1 Yes 2 No 9 Unknown	9 UINIOWII					1		
		Part II. Other significant conditions	contributing to death but r	not resulting in the i	underlying cause g	given in Part I.				cause of death?
signe	od by						- 122		200	ly 4 Unknown
ords	lete							opsy	prior to com death?	sy findings avaitable ipletion of cause of
ecc he lav ate na age 2	Completed							formed?	1 Yes	2 No
tal Rection: he	B B	25. Was case referred to medical examiner?				of Death (Chec	ck only one)			
Vita hysici this c	0	1 🗸 Yes 2 No	Hospital: 1 Inpatient 2		F. 7		sing Home 5	Residence		
Division of Vital Records, P.O. pital or Attending Physician: he law requires that thours after death reral Director: After this certificate has been signed by filled in by the funeral director, age 2 should be detacl	Ë	27. Manner of Death 1 Natural 5 Panding	28a Date of Injury (Month, Day, Year) FOUND:	28b Time of FOUND:	· · _ ·	ry at Work? Yes 2 ✔ No	Subject ha	e how injury occ anged self	currea	
IVISIOF or Attend after death Director:	aţic	2 Accident Pending	ion May 24, 2006	0615 hrs			206 Leasting	(Ctanat and No.	mbas as Busal	Route Number, City
JVIS Jor A after U Dire	Certification:	3 Suicide 6 Could not determine			ет, тастогу, опісе в	ounding, etc.	or Town			
. E 8 5 E		4 Homicide	ian: To the best of my know		errad at the time. de	ate and place				
To the Hos within 24 h To the Fur	ical		r:On the basis of examinati	on and/or investiga	ition, in my opinior	n, death occurre	d at the time, da	te and place, ar	nd due to the c	ause(s)
To with To I	Medical	20b. Signature and title of certifier	and manner stated		29c. Licens	se number		29d Date s	signed (Month,	, Day, Year)
		() a l.	201111		O.C.	M.E.		May 25,	2006	
\bigcup_{n}	(30 Name and address of person who	completed cause of death	(Item 23a)			1,240.0			
5	1		tant Medical Examin		n Street, Baltir	more, MD 2	1201			
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	who	-	-			
Regist	rar	MAY 3 0 2	006 Bloque	1.5 15	Carried Marie					

		For State		State of W	-			lealth and N	nental Hy	-	M M M	16010
		State Registrar 1. Decedent's Name	(First Middle I	ast)	(Sertific	ate of	Death	2. Date of D		2006	3. Time of Death
hysicia /Medic				A GEORGE					May		2006 ^{Year}	
amin			not institution, gi hurch F	ive street and number Road)		Par	r Locetion of Death kville				imore
eral ctor		5. Social Security No. 260–60–9	687	Sex 7. A	ge (In yrs. last birth	day) If U Mor	nder 1 Year ths Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D NOV. 5	irth ay Year 194	9. Bi	irthplace (State or Foreign Country) Orgia
M 11		Usual Residence of 10a. State	10b. County		10c. City, Town	or Location						10d. Inside City Limits
pegin	ctor	MD	Ba]	Ltimore		Park	ville					1 ☐ Yes 2X No
at be no	Funeral Director	10e. Street and Nun 2917 Chu		i		10	. Zip Code	21234		10g. Ci	tizen of What C USA	Country?
isal Examinar must be notified at	by	11. Marital Status 1 ☐ Never Marrid 3 ☐ Widowed		12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?		ecedent of H specify Cuba as 2 XNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh Specify:	
dical	eted	(Speci	15. Decedent's tify only highest g	Education rade completed)	16a. [Decedent's Give kind o	Usual Occup	nation during most of work d)	ing	16b. K	(ind of Busines	s/Industry
The Med	Completed	Elementary/Secon	ndary (0-12)	College (1-4or	5+)		hier	<i>a)</i>		Sup	ermarke	ert
event,	To Be C	17. Father's Name (Joseph		Higgins,	Sr.			18. Mother's Nam Winnie		e, Maider	n Sumame)	
other traumatic eve		19a. Informant's Na Francis	John ((Type, Print) George, Jr.:	Spouse 29	Mailing Add	ress (Street nurch	and Number or Rui Road-Pa	al Route Numi	ber, City o	or Town, State, ID 212	Zip Code) 34
any injury or other tra		20a. Method of Disp 1 ☐ Burial 2 [`4 ☐ Donation	XCremation 3	□Removal from State	20b. Place of learning Evans Chape	Disposition cremators FUT	(Name of or other place erai Air	ce)	Date 26-06		est H	r Town, State ill, Marylar
importa any inju once.		21. Signatore of Fu			1	22. Nam	e and Addre	es of Facility		ERAL	CHAPEI	
5 5 3	-	Cona	se hyl	mplications that cause	od the death. Do so		0 Har				CHAPEI 11e,MD	
sician		shock, or hear Immediate Cause (disease or condition	rt failure. List on! Final	y one cause on each	line.	2	Lanom	ig, such as cardiac	or respiratory	ariest,		Approximate Interval Between Onset and Death
dical iner		resulting in death)	- (_ a	s a consequence of							3)-2-2
	er	Sequentially list cor if any, leading to im	nditions, mediate	b. — Due to (or a	s a consequence of):						
the burial-transit	Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or that initiated events	rlying injury	c		_						
e puriai-		resulting in death) L	.ast	Due to (or a	s a consequence of):					_	
for use as the bi	Med	IF FEMALE:	a	23c. If yes, outcome	o of programmy							
ched for us	Physician/Medical	23b. Was decedent in the past 12 1 Yes 2 2 Unknown	months?	1 Live birth	2 Fetal death		ic pregnancy r (specify)	/			23d. Date of de Month	alivery Day Year
signed by the	þ	Part II. Other signifi	icant conditions	contributing to death	but not resulting in	the underly	ing cause giv	en in Part I.			1	to the cause of death?
should	iete								24a. Wa	s an	24b. Were a	utopsy findings available
page 2	Completed								auto perf 1 Yes	ormed?	death?	completion of cause of s 2 \sum No
irector, pag	o Be	25. Was case referrexaminer?	red to medical	Hospital:	0 [[EB/Outs	ations of	TDOA Oth	26. Place of Deat			2 Floring (2)	
After this funeral di	-	27. Manner of Death	·	1 ☐ Inpat 28a. Date of Inj (Month, D			28c. Injur	y at k?	28d. Describe		6 ☐Other (Speny occurred	вспу)
y the	Certification:	2 Accident 3 Suicide 4 Homicide	investigati 6 Could not determine	be 28e. Place of Ir	njury - At home, farr	m, street, fa		Yes 2 No	28f. Location City or To			Rural Route Number,
To the Funeral Diractor: completely filled in by the	ai Cer	29a. Certifier	1 Certifying I	Physician: To the bes		death occu	rred at the tir	ne, date and place,	and due to the	cause(s) and manner a	s stated.
the Fur	edical	(Check only one)	2 ☐ Medical Exa									
To COT	Σ	29b. Signature and	title of certifier	1. Inta	1 hm	-	29c. Licens	e number		29d. Da	ite signed (Mon	to the cause(s) oth, Day, Year) o, 2006 Dally 100
		30. Name and addre	ess of person wh	completed cause of	death (Item 23a) (T	ype, Print)					2	1 222
0		Willia	m a	Isterf.	eld 1	10.	91031	Frankl	n 59 1	2.5	+ 2200	Dilta MD
<u> </u>		31. Date filed (Mont	D	and the second	d- C'							

DHMH 17 Rev 1/2001

06-03588 D

5-03588		Please Type or Print in Black Indelib		_		
evyn Alexis Gio			vlental Hygier	ne	200	6 1682
-	- 1	1- For State Certificate of Death			No = 00	
Physicia Medical Examir	110	1. Decedent's Name (First, Middle, Last)	Mor	e of Death oth (y 27, 200	Day Year	3. Time of Death 0903 hrs
neuicai Examii		Devyn Alexis Giordano 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loca		y 21, 200	4c County of Dear	th
		4023 Rustico Road Nottingham			Baltimore Co	unty
Funeral		o. dedian detailing it is a second of the se		ate of Birth	(MM/DD/YYYY) 9 B	
Director		214-73-8750 1 M 2 F Yrs. Months Days 10 21	Hours Min.	lly 6	, 2005 Fore	ountry) MD
	ŀ	Usual Residence of Decedent		11.9	, 2000	
, any	ſ	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show d at once.	ъ	MD Baltimore Perry Hall				1 Yes 2 X No
Maryl 28a-1	Director	10e Street and Number 10f. Zip Code		100	g. Citizen of What Co	untry?
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene is a marked other than "natural", or items 23a or 28a-f she ratic event, the Medical Examiner must be notified at once		2 Knightsbridge Court 21236			USA	
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispania 14. Never Married 15. Was Decedent of Hispania 16. Armed Forces?			14. Race - Ame White, etc.	rican Indian, Black,
r deat	딃	1 Yes 2 ^ No			Consider .	white
11215-0036 Id be filed within 72 hours after formal Hygiene narked other than "natural", event, the Medical Examiner.	2	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No spont Specification (Specify only highest grade completed) 16a. Decedent's Usual Occupation (ne f	Specify 16b Kind of Business	
2 hour	te -	Elementary/Secondary (0-12) College (1-4 or 5+)				
36 hin 72 than	亂	0 dependent			N/A	
d with	Completed		Mother's Name (First,	Middle, Ma	aiden Surname)	
21215-0036 uld be filed within 72 Mental Hygiene marked other than c event, the Medical	Be (Bobby Bell SI	hannon Bol	ing		
21 ould b	2	19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and				
nore, MD 21218 gges I and 2 should be file nt of Health and Mental F II: If item 27 is marked other traumatic event i		Shannon Boling / mother 2 Knightsbridge		Perry		
ore, of Hea If iter		20a Method of Disposition 1 Burial 2 A Cremation 3 Removal from State 20b Place of Disposition (Name of cemete crematory or other place)	ery, Date		20c Location - City of	ir Iown, State
1 3 H 2 H 2 H		4 Donation 5 Other Specify. Hilltop Service Corp		5	Towson, M	
Baltimore, permit. Pages I at Department of Hee Important: If ite	- 1	21. Signature Furieral Solvice Licensee 22. Name and Address of F			1050 Yor	
	_	Ruck Towson 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such	Funeral Ho	ome		MD 21204 Approximate Interval
Physician /Medical		failure. List only one cause on each 炬	ar as cardiac or respir	atory arres	st, shock, of fleat	Between Onset and Death
Examiner	1	Immediate Cause (Final disease or condition resulting in death) Sudden Unexplained Death in Infancy Due to (or as a consequence of):		_		Deatti
1		h				
	声	if any, leading to immediate Due to (or as a consequence of):				
	Examiner	(Disease or injury that initiated expenses within a death) last consequence of).				1
nted d ansit	Ä	events resulting in death) Last Due to (or as a consequence of). d				
be executed ician and irial - transit	dical	X UNPENDED AMENDED item#23a_27_28a_f_perME_G858.	0/01/06 999			
60, ate be hysic ie bur	Med	IF FEMALE: 23c If yes, outcome of pregnancy	8/31/06 11		23d Date of delive	ry
687 ertific ding p	an/	past 12 months?	Ectopic pregnancy		Month	Day Year
Box 68760, s death certificate be the attending physicical for use as the burned for use	Physician/Me	1 Yes 2 V No 9 Unknown 9 Unknown				
O. B at the d I by the	P.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver	n in Part I. 2	3e. Did tob	acco use contribute t	o the cause of death?
Division of Vital Records, P.O ral or Attending Physician: The law requires that t rs after death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced in by the funeral director, page 2 should be detaced.	by			1 Yes	2 No 3 Pro	obably 4 🗸 Unknown
ords, w requir s been s should t	etec		2	4a. Was ar		autopsy findings available completion of cause of
COI e law i e 2 sh	Completed			autops perforn Yes 2	ned? death?	· possessing
Vital Rec ysician: The I his certificate I		25. Was case referred to medical 26. Place of I	Death (Check only or		No 1 🗸	165 2 140
/ital	o Be		ner ₄ Nursing Hom		Residence 6 🗸 Oth	er: Scene
1 of \ding Phy	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at	t Work? 28d [Describe ho	ow injury occurred	
On endin ath. or: A	tio	1 Natural 5 Pending Fnd 5/27/2006 Fnd 8.53 am 1 Yes	² X No u	nk		
ivision or Attene after death Director:	lfica	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office build	ding, etc. 28f. L	ocation (St	treet and Number or F	Rural Route Number, City
Division ppital or Attent cours after death terral Director: filled in by the	Certification:	4 Homicide determined (Specify) found in bed	Noti	tinghar	n, MD Rust	LICO KOAU
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funceral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	al C	29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date a	and place, and due to	the cause	e(s) and manner as sta	arted
To the Hos within 24 h To the Fun	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, de and manner stated				
	Σ				29d. Date signed (M	onth, Day, Year)
		Jotu (Ronie tollen O.C.M.E	⊏. 		May 28, 2006	
0		30. Name and address of person who completed cause of death (Item 23a) Potricia Archica Pollak MD Assistant Medical Evaminer 111 Penn Street	et, Baltimore, MI	21201		
		24 Data filed (March Day Vess) 22 Projector's Signature		2 2 1 2 0 1		
S	tate	31. Date filed (Month, Day, Year) 32. degistrar's Signature				

			For State Registrar	State of M	1aryland		artment rtificate			nd M		giene Reg. No.	006	16	821
I	Physici /Medio		Decedent's Name (First, Middle, La ALBERT					DDIN			2. Date of Dea Month MAY		2006	3. Time of 5:15	of Death
	Examir Funeral	er	4a. Facility Name (If not institution, given GENESIS HEALTHCA 5. Social Security Number 6. S	RE-LONG G		ast birthday)	If Under	BAI 1 Year	_ocation of _TIMO If Under 2	RE 4 Hrs.	8. Date of Birt	h	BALTI 9. Birth	MORE	or Foreian
	Director		219-05-8579 Usual Residence of Decedent 10a. State 10b. County	1 M 2□F	84	Yrs.	Months	Days	Hours	Min.	08/13/	/1921	Cou	M 10d. Inside C	D
	r 28a-1 eho	rector		IMORE		TOWSO		Code				10g. Citize	n of What Cou	1 🗆 Yes	s 2 No
9	72 hours after death with the Maryland naturel', or itema 23a or 28a-1 ehow dical Exeminat must be mailled at	Funeral Director	1055 WINSFORD RC	12. Was Deceden Armed Forces 1 (X) Yes 2 [If Yes, Give	i?] No			ent of His fy Cuban			city Yes or No- Rican, etc.)		Race - Ameri Black, White	, etc.	
21215-0036	Jwithin 72 hours : Jiena r than "naturel", Ine Medical Exe	Completed by	3 🕅 Widowed 4 🗆 Divorced 15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	Year or Dates:		16a. Deced (Give life.	1 ☐ Yes 2 dent's Usual kind of work DO NOT use	Occupat k done du	Specify:	of workin	ng	16b. Kind	of Business/In	WHIT	<u> </u>
	be filed stal Hyg od othe event,	To Be Con	17. Father's Name (First, Middle, Last ABRAHAM)		SALES	N		18. Mother	's Name	(First, Middle,		SHOP mame)	SNYD	FR
re, Maryland	1 and 2 sho Health and tem 27 is m	-	19a. Informant's Name/Relationship (IRIS KNOX / DAUG 20a. Method of Disposition	Type, Print) GHTER	20b. Pla		WINS	FORD	ROAD	- T	OWSON,	MD 2		p Code)	
Baltimore,	permit. Pages Department of Important: If I eny Injury or o		1 A Burial 2 Cremation 3 C 4 Donation 5 Other (Special Signature of Funeral Service Lice	(y)	8 1	AWITZ	NUSAC . Name and	H AR	I (NE	R 5 SOL	728/06 LEVINS	SON &		INC.	
8760,	Physician /Medical Examiner	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	Inne. Inne. s a conseque s a conseque s a conseque Onon	ence of): And Centre of of of the centre of of of of of of of of of of of of of	A.	RR	rry	TIF	MIT of A	4	4	Approxima Interval Be Onset and	tween
.O. Box 6	The law requires that the death certific the has been signed by the attending Foage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pre Other (spe					23d	l. Date of deliv Month	- 2	Year
<u>α</u>	w requires that been signed b should be deta	Completed by Ph	Part II. Other significant conditions of	contributing to death	but not result	Iting in the u	ndertyingca	use giver	in Part I.			es 2 🗆 N	/		Unknown
Vital Records,		Be Comp	25. Was case referred to medical examiner?						26. Place	of Death	autop perfor	sy med? 2 No	prior to co death? 1 \(\text{Yes}	2 □ No	cause of
Division of \	ial or Attending Physician: s after death. al Director: After this certifica ed in by the funeral director.	Certification: To	1 Yes 2 No 27. Manner Death 1 Tatural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	28a. Date of Inj (Month, D		28b. Time of Injury	M 28	Work?	4 KN Nur	lo 2	ne 5 Resid	ow injury o	ccurred		
Div	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		Check only 2 Medical Exal	building, e	etc. (Specify)	vledge, death	occurred a	t the time	a, date and	place a	8f. Location (S City or Tow nd due to the o	n, State)	d magner as e	stated	
	To the within 2 To the complet	Medical	29b. Signature and title of certifier For Better	and mariners	M	2	29c.	License	number			29d. Date s	igned (<i>Month</i> , 24/2	Day, Year)	
(l		30. Name and address of person who 75 0 5 05 LE	n so	70	DIVS	2N 1	ME	1 2	12.	04				
	Sta Registi		31. Date filed (Month, Day, Year) MAY 3 0 2	2006 32. Sis	trar's Signati	& A	serle	,							

		1	For State Registrar	State of Mar	ryland / [•	rtment of He tificate of D		lental Hy	giene Rag. No.	2006	16822
	٥ , ,		1. Decedent's Name (First, Middle, Last)						2. Date of De		Year	3. Time of Death
	Physicia /Medic		George E.	Harris	Jr.				May	26°	2006	6:00 AM
	Examin		a. Facility Name (If not institution, give s.				4b. City, Town, or I				County of Death	
			Annapolis Nursing		enter (In yrs. last bil	rth day.	Annapol	1 S If Under 24 Hrs.	8. Date of Bi	rth	ne Arun	UE I
	Funeral Director			M 2□F		Yrs.	Months Days	Hours Min.	4/13/	y, Year)	Cou	sylvania
	*	-	Usual Residence of Decedent		13				17107	1327		
	yland	. [10a. State 10b. County	1	10c. City, Tow	m or Loc	ation					10d. Inside City Limits
	e Ma	cto	MD Anne Arur	nde1	Riva							1 Yes 2 XNo
	ith th	Director	10e. Street and Number				10f. Zip Code			-	en of What Cou	intry?
	s 23a	ra	3098 Newington Dri	V C	10.5 H C	12 14	21140 Vas Decedent of His	nanio Origin? (Sn	ocity Vos or N		SA 4. Race - Amer	ican Indian
	ter de	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ☐XNo		If	Yes, specify Cubar	, Mexican, Puerto	Rican, etc.)		Black, White	
5	hours after death with the Maryland turel', or Items 23a or 28e-f show al Examinational be multified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 21X No	Specify:			Specify: Wh	ite
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	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)	Sv				Helen E		o, maiosir c	Jamamey	
Ž	d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 7 is marked other then "naturel", or Items 23a or 28e-f show the marked other then "naturel" or Items 23a or 28e-f show the under the marked of the Maryland Examination of the Maryland Examinat	P	George E. Harris S		198	o. Mailine	g Address (Street a			er, City or	Town, State, Z	ip Code)
Maryland 21215-0036	d 2 :		Linda Smith				lewington					
ē,	s 1 and 3 f Health item 27 other tr	1	20a. Method of Disposition		20b. Place o	of Dispos	sition (Name of natory or other place	9)	Date		cation - City or T	
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	Pnysician /Medical-		disease or condition resulting in death)	Due to (or as a			0115675	e ova	acolar	03	ens.	4-2015
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	n 11/=	ner	Sequentially list conditions, and, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consiguence	of):						
	and and trans	Examin	that initiated events resulting in death) Last	Due to (or as a	consequence	of)						
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/89	ficate be executed physician and street burial-transit	edical		J								
Box	attending for use a	Physician/Me	in the past 12 months?	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal deat		Ectopic pregnancy Other (specify)			2	3d. Date of deli Month	very Day Year
<u>о</u>	that the ded by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions cor	atributing to death but	t not resulting	in the ur	nderlying cause give	on in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
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Division of	or Attendii after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, t . <i>(Specify)</i>	farm, str	eet, factory, office			(Street and own, State)		ral Route Number,
	pitel	Ce	29a. Certifier 1 Certifying Phy	sician: To the best of	f my knowlede	ne. death	occurred at the tim	ne, date and place	and due to the	e Cause(s)	and manner as	stated.
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only one)	ner: On the basis of and manner stat	examination a	ind/or in	vestigation, in my or	oinion, death occur	red at the time	, date and	place, and due	to the cause(s)
	To the To the	Me	29b. Signature and title of certifier	.1)	29c. License	number		29d. Date	a signed (Month	n, Day, Year)
•	/		Buller	levire	Cmil	1	Do	1852		26	MAY	2006
	3		30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type,	Print)	E = 1010	DI L	1.1.4	te - 11-	1. Day, Year) 2006 Mi) Zo781
			31. Date filed (Month, Day, Year)	ORE,	r's Signatifus	4 14	25 CVUE	SUSBURY	Ra M	441	124/1/	1410 20 181
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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 2006 Michelle Κ. Hipple MAY 7:30 A. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimure Washington Hedical Center

5. Social Security Number 6. Sex 7. Age (In yrs. last birth. Glen Burnie If Under 1 Year If Under 24 Hrs. Anne Arundel Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🔀 F Hours Yrs. 212-98-1455 29 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10h County 10c, City, Town or Location 10a State or Iteme 23a or 28a-f ehow permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28e-1 ehow any Injury or other traumatic event, it a Medical Exarchar must be notified at once. 1 ☐ Yes 2 No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Crain Hwy North, Apt 881 21061 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ William R. Long Judv Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 102 Crain Hwy North Apt 881, Glen Burnie, MD 21061 (spouse) Justin T. Hipple 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 31 20c. Location - City or Town, State 20a. Method of Disposition May 1 XBurial 2 Cremation 3 Removal from State 2006 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery Glen Burnie, MD 21. Signature of Funeral Service 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or composition of heart failure. List only of plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner S- pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗷 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performer 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death
Natural
Control
Accident 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) 30 Hogania Dewe, Colen 31. Date filed (Month, Day, Year) State MAY 3 0 2006 Registrar

DHMH 17 Rev 1/2001

Tipple, Michelle

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 0 0 6 For State Registrar 16824 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Jean Arlene 6:07PM Hartman 26 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 M 200 219-32-8992 69 Yrs. Director 1937 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ul Hygiene other then "neture!" or iteme 23a or 28a-f ehow vent, it a Medical Exeminar must be notified at Maryland n/a Baltimore 1√2¥es 2□No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1422 Union Avenue Apt A 21211 USA filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ White 3XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Meter Maid Baltimore City permit. Peges 1 and 2 should be lile.
Depertment of Health and Mental Hyg Important: if Item 27 is marked other eny injury or other treums! 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alonzo Baker Pearl R Duckworth 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Fitzberger Daughter 3413 Pleasant Place Baltimore, Maryland 21211 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2☐Cremation 3 ☐Removal from State Metro Crematory 05/30/2006 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road, Baltimore, Maryland

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Address of 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aotic Anlunsm **Physician** 48hrs eaking /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of). Box 68760, physicien detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be 1 🗆 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manney Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 atural 5 Pending within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ceula J. Wa A12438946- c20 May 26 201 EAST UNIVERSITY PKNY BALTIMORZ, MD ZIZIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION MEMIRIAL HOSPITAL CECILIA WANG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 16825 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MURIEL JONES MAY 25, 2006 12:00AM /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10/23/1947 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**M 2□ F Days Hours 58 218-44-9605 Director MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or iteme 23a or 28e-f ehow the Medical Examinar must be notified at N/A BALTIMORE CITY 14 Yes 2 No MD Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 USA 6225 YORK ROAD, APT. E106 Funeral 12. Was Decedent Ever in U.S. Armed Forces? US 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married BLACK 1 ☐ Yes 3 ☐ No Specify: Specify þ 3 ☐ Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during 16b. Kind of Business/Industry during most of working Compi Elementary/Secondary (0-12) ARMY NATIONAL GUARD College (1-4or 5+) MILITARY 10TH other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be le marked JOSEPHINE JONES ROBERT GUSTUS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212 19a. Informant's Name/Relationship (Type, Print) 6225 YORK RD, APT. E106, BALTIMORE, If Item 27 I JOSEPHINE JONES / MOTHER 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State MD TERANS TO CEM 1 🌠 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If eny injury or once. 5/31/06 OWINGS MILLS, MD 4 Donation 5 Dother (Specify) GARRISON FOREST 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, M. 21. Signature of Funeral Service Licensee Parts Enter the Alsease, or complications that caused the destance, or hear failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** PULMONARY TUBERCULOSIS /Medicat Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): attending physician Physician/Medical use þ Completed peed page 2 s 785 Be P

To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After this I Director: /

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 □ Probably 4 □ Unknow
		24a. Was an autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
25. Was case referred to medical	26. Place of Dea	h (Check only one)
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence 6 Other (Specify)
27. Manner of Death 1 X Natural 5 ☐ Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Injury M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)

D 37254

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29b. Signature and title of certifie 29c. License number

29d. Date signed (Month, Day, Year) 06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601 BOON P.LIM M.D. OSLER DRIVE TOWSON MARYLAND 21204

31. Date filed (Month, Day, Year) 0 2006

within 24 hours a To the Funerel I

Certification:

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State

State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month-**Physician** MOSKINSON 200 4a. Facility Nanie (If not institution, give street and number) /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Westminste. Carroll Putp 05/011 If Under 24 Hrs. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 ☐ M 2 😾 F 62 287-38-4510 Director 4/11/1944 Ohio Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show item 27 ie marked other than "natural", or itams 23a or 28a-f ebov other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director BALTIMORE CITY MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21208 USA 9050 IRON HORSE LANE, APT. 430 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. In Inportant: if item 27 ie marked other than "natural; or itan ery injury or other traumatic event, the Medical Exercised page. Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HEALTH REGISTER NURSE 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **GERTRUDE** BONHAM WILLIAM HAROLD HOSKINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 245 VEGAS 9225 WEST CHARLESTON BLVD, UNIT 1051, NV8911 ALLEYN DAVIS - NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ALL COUNTY CREMATION 5/29/06 SYKESVILLE, MD □ Donation 5 □ Other (Specify) Signature of Fyneral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or beart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** cancer resulting in death) /Medical Due to (or as a consequence of): Examiner rebravasca Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the attending physician and the for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☑ No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ ₩o should peen 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed certificate 1 Yes 2 No 1 Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Apatient Medical Certification: To 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Dale of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, address of per on who completed cause of death (Item 23a) (Type, Print) St 327 Westmanster MD 31. Date filed (Month, Day, Year) State MAY 3 0 2006 Registrar

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Fune Direct			5. Social Security Number 165-24-3018 Usuel Residence of Deceder		ex □M 2[3][F	7. Age	(In yrs. la	Yrs.	Month	ler 1 Year s Days		Hrs. 8. Min.	Date of Bir (Month, Da ept. 1	th ly, Year) 8,19	29	_ Coun	lace (State of try) sylvan	-
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ながらら		30. Name and address of person who cou	npleted cause of death (Iter	n 23a) (Type, Pi	RE:	5000	0	~ / ~	21237 NORE, MID
Sta Registr	-	31. Date liled (Month, Pay, Year) MAY 3 0 2006	2. Registrar's Sign	CIOO ature	0 Fea	nkin s	quaredi	e. Baltin	IORE, MD

State of Maryland / Department of Health and Mental Hygien () [] []

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Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day 22, **Physician** MAY 2006 16:35 NELLIE M. MACEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL 432 OUEENSTOWN ROAD SEVERN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country) MARYLAND 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2√☐ F 92 213-14-2884 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State r than "natural", or items 23a or 28a-f ehow 1¶ Yes 2 No ANNE ARUNDEL SEVERN MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21144 USA 432 OUEENSTOWN ROAD 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2M No Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK If Yes, Give Year or Dates: þ 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) WESTINGHOUSE al Hygiene. Elementary/Secondary (0-12) 7 TH Cottege (1-4or 5+) CORPORATION CUSTODIAN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental and Mental RACHEL HALL ANDREW MOORE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 432 QUEENSTOWN ROAD, SEVERN, MD 21144 BARBARA A. JOHNSON/DAUGHTER f Health i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Baltimore. 20a. Method of Disposition ō <u>=</u> 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 permit. Page Department of Important: if eny Injury or once. ARBUTUS MEM. PARK 5/31/06 BALTIMORE CO., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, the Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or hear failure. List only one cause on each line. Approximate Interval Between fmmediate Cause (Final diseate or condition resulting in death) rears **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ysician and e burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Completed by all 2 No 3 Probably 4 Unknown 1 Tyes peeu 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be examiner? Other: 4 Nursing Home Hospital: 5 Residence 6 Other (Specify) 2 3 DOA 1 Inpatient 2 ER/Outpatient 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Naturat Accident 5 Pending s after dea. 1 ☐ Yes 2 ☐ No investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 6 within 24 hours a
To the Funeral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 0 Date fifed (Month, Day, Year) State

Registrar

0 2006

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Re	Stat egistra	~	31. Date filed (Month, Day, Year) MAY 3 0 2006		strar's Signa										

06-03409 Cynthia Moody

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Certific	ate of	Death			Reg	g. No.	200	6	1683
Physicia		Decedent's Name (First, Mid-	ile,Last)							Date of Death		Year		e of Death
dical Exami	iner	Cynthia E. 4a. Facility Name (if not instituti	Moody						1	May 20, 20	06			28 hrs
				d number)		4	b. City, Town, o	or Location of	Death			ounty of Death		
		Anne Arundel Medica		7 Ass //s	ra laat bid	hadou)	Annapolis	or Hilloder	Ödtler I	P. Data of Birth	1	ne Arundel		(Charles and
Funeral Director		5. Social Security Number	6. Sex	7. Age (In y			If Under 1 Ye Months Da		1.0	B. Date of Birth		Foreig	gn	
Director		214-66-5203	1 M 2 X	F	50	Yrs.				12/6/1	955	Co	ountry)	NY
any		Usual Residence of Decedent 10a, State 10b, County	,	10c. (City. Town	or Location	on						10d In	side City Limits
<u>*</u>		Ma	e Arund		Anna				1					Yes 2 X No
ylanc a-f sh	ctor	10e. Street and Number	= ALUIIG	eı	Allila	ipor.	10f. Zip Code			10	a Citizen	of What Cou	l	-A
and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show a traumatic event, the Medical Examiner must be notified at once,	Director	29 W. was	hinotor	Stree	t			1401			_	USA		
oith the 5 23a s noti		11. Marital Status		Decedent Ever i		13. Was	Decedent of H	ispanic Origi	n? (Spec	ıfv Yes or No-		. Race - Amer	rican Indi	an Black
r death v or item must b	uneral	1 Never Married 2 X	namou	ed Forces?	1-		s, specify Cuba					White, etc.		
fter d	யட	3 Widowed 4 D	vorced If Yes, Give		10	1	Yes 2 X N	o specify:			Spe	ecify: Af	rie?	an-
urs a	d by	15. Decedent's Education (Sp	or Dates: ecify only highest	grade completed	d) 16a.		s Usual Occup					of Business/		Jun
72 hc n "ns al Ex	Completed	Elementary/Secondary (0-12	Colleç	ge (1-4 or 5+)		_	st of working lif)				
5-0036 led within 7 Hygiene. I other than the Medica	шb	12th			Co	mpu	ter Op	erato	r		C	orp.	Firn	n
5-0 led w Hygir othe	ပိ	17. Father's Name (First, Middle	, Last)					18. Mother's	Name (F	irst, Middle, M	aiden Sur	mame)		
121 l be fi ental	Be	George Elli 19a. Informant's Name/Relation	ott				Address (Stre	Mari	on I	. Wal	lac	e		
21 Should I and Mer is man	To													
MD and 2 sho alth and 27 is raumat		Thomas L. Mo	ody/ So	n	Ob Place	Ceo	<u>iar He</u>	ights	Ct.	, # B,	WO. 100	odlaw:	n, P	Md 2120 State
of He		1 X Burial 2 Crematic	n 3 Remov	1	cremat	ory or oth	er place)							
Pag ment tant:		4 Donation 5 Other 3			Mt.		n Ceme							
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		21. Signature of Funeral Servic	1//////////////////////////////////////	1			ame and Addre							
		23a. Part I. Enter the disease, o	or complications th	nat caused the de	ath Don	1920	00 Lib	erty	Rd .	, Rand	all	stown	, Mc	d 21133 eximate Interval
Physician /Medical		failure. List only one caus	e on sach line.						i dide of te	spiratory arres	st, shock,	Of Healt	Betw	een Onset and Death
Examiner		Immediate Cause (Final diseas or condition resulting in death)		nsive Athero		Cardio	ovascular D	tsease					┿	Deali
P ₃			b.	as a consequent	oo or _j .									
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ficate be executed g physician and the burial - transit	dical	UNPENDED	AMEND	ED		·							\top	
60, ate be	Med	IF FEMALE:	23c. If y	es, outcome of p	pregnancy					·	23d. D	ate of deliver	<u></u>	
687 ertific ding p	an/	23b. Was decedent pregnant in past 12 months?	- L	ive birth	2	Feta	aldeath 3	Ectopic	pregnancy	<i>y</i>	Мо	onth [Day	Year
Box 68760, he death certificate by the attending physic hed for use as the but	Physicia	1 Yes 2 No 9 🗸 U	akpowe	regnant at time o	of death	5 Oth	er (Specify)							
the d	Phy	Part II. Other significant cond			not resultin	a in the ur	nderiving cause	given in Par	t I.	23e. Did tob	acco use	contribute to	the caus	e of death?
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach	by	Renal failure					-			1 Yes	2 N	o 3 Prol	bably 4	✓ Unknown
ds, equire een si	Completed				-					24a. Was ar	n	24b. Were au	utopsy fir	ndings available
Cor law r has b	ldu									autops perforn		prior to death?	completio	on of cause of
Re The ficate page	S	0.5	1				00.54			1 Yes 2	No	1 🗸 Ye	es	2 No
ital ician: s certi	Be	25. Was case referred to medic examiner?	Hospital:	Inpatient 2	FRIO.	utnotiont		Other	Nursing F			0 000		
of Vi ing Physi After this uneral dir	ျ	1 ✓ Yes 2 No 27. Manner of Death	28a. [Time of In		ury at Work?		d. Describe ho	esidence		n .	
	ion	1 Natural	nding (N	Date of Injury Month, Day, Year)				Yes 2				20001104		
Sion Attender or death rector: by the	ication	2 Accident Inv	estigation 289	Place of Injury -	At home, fa	arm, stree				f. Location (St	reet and	Number or Ru	ırai Rout	e Number, City
Divi	ertifi		uld not be ermined (Spe				,,	J		or Town, Sta			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Hospi 4 hou Funer ely fil	0	29a Certifier	hysician: To the	best of my knov	vledae. de:	ath occurr	ed at the time.	date and place	e and du	e to the cause	(s) and m	anner as star	ted	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only Certifying one) 2 Medical Ex	aminer: On the ba	asis of examination										(s)
To To	Me	29b. Signature and title of certif	and manr ier	ier stated.			29c. Licer	nse number		1	29d. Date	e signed (Mo	nth, Day	, Year)
4		Sand For the	1/201				0.0	.M.E.				0, 2006		
,		30. Name and address of person	n who completed	cause of death (Item 23a)									
'b		Pamela Southall, MD		Medical Exa		111 P	enn Street,	Baltimore	, MD 21	201				
	tate	31. Date filed (Month, Day, Year	1000	2. Registrar's Sig	nature	1 10								
Regis	trar	MAY 3 0 2	.UU5 /10	war of		ABARL.	0							

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 5.7.8 per fh 2856 6-6-06 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2006 Helen P. Mills MAI 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Union Memorial Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1926 Month, Day Yrs. Days Hours Min. Jan. 28, 1925 5. Social Securit**8610**er 219–10–8319 9. Birthplace (State or Foreign 6 Sex **Funeral** 1 □ M 2 15 T F Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f ehow the Medical Examiner must be notified at XXYes 2 □ No Maryland N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 USA 700 W. 40th Street "natural", or iteme 23a deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Peges 1 and 2 should be filed within 72 hours atler nent of Health and Mental Hygiene. ent: if item 27 ie merked other then "natural; or lite ary or other treumatic event, the Madical Examina. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: White Specify: ģ 3 Widowed 4 Divorced Be Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ada Childress Robert Norris Talbot ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
700 W. 40th Street Baltimore, Maryland 21211 19a. Informant's Name/Relationship (Type, Print) Frank W. Mills, Sr. 1 Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State permit. Pege Department Importent: If any Injury or once. Metro Crematory 5/27/2006 Catonsville, Maryland 4 □ Donation 5 □ Other (Specify) Fineral Service Licensee 21. Signature 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home. 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 30415 /Medical Examiner oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed RUFEUSION 10 and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE: . If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown ate has been signed by the atta page 2 should be detached for Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b Time of 28d. Describe how injury occurred Aftar Naturat 2 Accident 5 ☐ Pending death. 1 ☐ Yes 2 ☐ No nerel Director: A rilled in by the fu investigation 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and fille of ceptifier 29c. License number person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 3 0 2006 Registrar

		1 - S	or tate egistrar			State			Ce	rtificat	te of I	Death			Reg. N	$Z\Pi$	U 6	1683
Physic				e (First, Midd Charl			er							2. Date of D Month	eath	ay	Year 2006	3. Time of Deat
/Medi Exami		4a. Fa	cility Name (If not institution	on, give	street an	id number) TAC)				Location of				Ic. County	y of Deat	
 Funeral Director 		219	ial Security N 9-26-1 Residence o	440	6. Ser	¥ 9M 2□	7. Ag	67 67	last birthday, Yrs.	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D Jan.	Sirth Day, Yea 3, 1		9. Birt	thplace (State or Fore puntry) aryland
Maryland a-f show	ctor	10a. S		10b. Count	•				ity, Town or L altimoi									10d. Inside City Lin 1 XYes 2 □
th with the 23a or 28	Funeral Director		treet and Nu 16 Wil	mber son Av	e.						p Code 1207				10g. (USA		ountry?
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Hospital or Attanding Physicien: The law requires that the death certificate be executed to the continuous after death. Funeral Director: After this certificate has been signed by the attending physician and in positive funeral director, page 2 should be detached for use as the burial-transit and positive funeral director.	To Be Completed by Physician/Medical	Immedisearesulti Sequeir arry, cause Cause Cause that in resulti IF FEN 23b. Vi in 199 Part II. 25. War exit in 199 27. Ma 1 200 29b. S	diate Cause se or condition in death) entially list contending in death) entially list contending in death) MALE: Was decedent in the past 12 Yes 2 Unknown Other signification Accident Suicide Homicide Certifier Check only one)	onditions, mediate or medicate	ions consider all H	Du Du Du Du Du Du Du Du Du Du Du Du Du D	e to (or as se to	a consequence of pregna 2 Feta t time of doubt not resulting y Year) of my knot fexamina ated.	quence of): quenc	der the model of the control of the coursed overstigation (29c)	regnancy pecify) DA Other 28c. Injury Work 1 1 y, office at the tim n, in my op c. License	e, date and inion, deat	oring cardiac of Death of Death rsing Hor	23e. Did 124a. Wa 24a. Wa 24a. Wa 1 Yes 28d. Describe 28f. Location City or To	tobacco tobacco tobacco s an ppsy lormed? 2	23d. Da Mo use cont 2 No 24b.	were au prior to c death? 1 Yes The ref (Special of the second of the	Approximate Interval Between Onset and Death Support of Section 1988 (1988) Approximate Interval Between Onset and Death Support of Section 1988 (1988) Approximate Interval Policy (1988) Appr

MULLER, ROBERT C.

C.

5/30/06

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logit	es								IAY		2006	1:27 A
treet and nu	. ,			4b. City,	Town, o	Location	of Death			4c. Count	y of Death	1
ledic	al (Cent	er			T	0W50	חנ			Balt	imore
M 2□F	7. Age		st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	719	715	9. Birth Cou Ne	pplace (State or Foreign untry) W York
e		_	Town or Lo	cation								10d. Inside City Limits
				10f. Zip	Code 212	86			10g	Citizen of Ur		States
2. Was Dec Armed For 1 Tes If Yes, Gi Year or D	orces? 2 X No ive		1	Vas Deced Yes, spec	ify Cuba	ispanic Or in, Mexicai Specify:	n, Puerto	ecify Yes or N Rican, etc.)	lo-		ck, White	ican Indian, , etc. White
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solog	ites					18. Mothe		e (First, Middle		_{den Sumar} ukala	-/	

21286

20c. Location - City or Town, State

Baltimore, Maryland

22. Name and Address of Facility Ruck Towson Funeral Home,

1050 York Road, Towson, Maryland Approximate Interval Between Onset and Death

resulting in death) Last

Due to (or as a consequence of)

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Completed by Physician/Medical

Be

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Certification;

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24 hours after deat • Funerel Director;

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D

State Registrar

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY EDEMA

24a. Was an autopsy performed 1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

20 No 3 Probably 4 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

5 Pending investigation 6 Could not be determined

1 Xinpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28c. Injury al Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

1 Tyes

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person pleted cause of death (Item 23a) (Type, Print)

M. D.

7601 OSLER DRIVE TOWSON MARYLAND 21204

D 24034

31. Date filed (Month, Dav. Year)

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

			1- For State of Maryland / Department of He Registrar State of Maryland / Department of He Certificate of D	ealth and Mental Hyg	
	Physic /Med Exami	ical	1. Decedent's Name (First, Middle, Last) RALPH MEYERSTEIN 4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER RANDALL	Location of Death	Year 3. Time of Death Year 2.45 A M 4c. County of Death BALTIMORE
1	Funeral Director			Hours Min. 8. Date of Birth Month, Day 07/25	9 Birthplace (State or Forming
	the Marylenc 28a-f ehow notified at	rector	10a. State 10b. County 10c. City, Town or Location MD BALTIMORE OWINGS MILLS		10d. Inside City Limits 1 ☐ Yes 2 [X] No
336	be filed within 72 hours after death with the Maryland hal hygiene. Id other then "neturel", or iteme 23a or 28a-f show event, it a Medical Examinat must be notified at	by Funeral Director		21117 panic Origin? (Specify Yes or No-Mexican, Puerto Rican, etc.) Specify:	USA 14. Race - American Indian, Black, White, etc. Specify: WHITE
d 21215-0036	filed within 72 hos Hygiene. other then "neture ent, the Medical E	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-10) College (1-4or 5+) Table 16a. Decedent's Usual Occupati (Give kind of work done du life. DO NOT use retired) MANAGER	ring most of working	16b. Kind of Business/Industry RETAIL
Maryland	should be ind Mental ind marked o	To Be	ALFRED MEYERSTEIN	Mother's Name (First, Middle, I META d Number or Rural Route Number,	HERZ
	1 en Heel		MICHAEL MEYERSTEIN / SON 2 IVORY CREST 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	COURT - BALTIMOF	RE, MD 21209 20c. Location - City or Town, State
Baltimore,	permit. Pages Department of I Importent: If it eny injury or o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address 8900 RFIST	of Facility SOL LEVINS	WOODLAWN, MD SON & BROS., INC. PIKESVILLE, MD 21208
	Physician	Ilcal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Interval Between Onset and Death
P.O. Box 6	Attending Priyatclent: The law requires that the death certificate be executed at death. After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
Records, P	w requires that been signed b should be deta	۾	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given i		acco use contribute to the cause of dealh?
па нес	ysician: The tav is certificete has director, page 2 :	Be Completed	25. Was case referred to medical		prior to completion of cause of death? No 1 ☐ Yes 2 1 No
DIVISION OF VITAL	tending Physic leath. tor; After this ce the funeral direc	Certification: To E	1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Cther. 27. Manner of Death 1 Natural 5 Pending	Nursing Home 5 Residen Residen Residen Residen Residen Residen	ice 6 Other (Specify)
=	5 4 5 0		4 Homicide determined 25e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Chy or Town,	
1	within 24 hours a within 24 hours a To the Funeral Completely filled i	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinic and manner stated. 29b. Signature and title of certifier 29c. License nu	mber 290	d. Date signed (Month, Dey, Year)
	Sta Registra	te	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1:6) NC 1 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	SER P MEHTO AUSTOWN N	A . 21133.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

			1 - For State Registrar	State of Marylan		irtment of F tificate of			Giene	6 6836
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) Freda Lavir		ock			2. Date of Dea	Day Ye	C I I I I I I I I I I I I I I I I I I I
}	Examir Funeral Director		4a. Facility Name (If not institution, give s	street and number)	last birthday).	4b. City, Town, of If Under 1 Year Months Days	Sedale If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Da) 6/28/19	4c. County of D	
	lend wo		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	cation				10d. Inside City Limits
	e Mary	Director	Maryland Baltimon	re Es	sex					1 ☐ Yes 2 No
	with th	i Dire	10e. Street and Number	206		10f. Zip Code			10g. Citizen of What	Country?
30	n 72 hours after death with the Marylend "natural", or Iteme 23a or 28e-f show splical Examinat must be notilited at	by Funerai		t 206 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 No If Yes, Give		21221 Vas Decedent of H Yes, specify Cuba	dispanic Origin? (Si an, Mexican, Puerti Specify:		Specify:	merican Indian, /hite, etc.
9500-612	"nat	Completed b	15. Decedent's Educ (Specify only highest grade	year or Dates: cation completed) College (1-4or 5+)	(Give I	ent's Usual Occup kind of work done OO NOT use retired	during most of work	king	16b. Kind of Busine	White pss/Industry
7	illed within I Hygiene. other than		17. Father's Name (First, Middle, Last)	College (1-401 37)	Homema	aker	40.14.15.11	(F) . A 61	Own Home	
yland		To Be	Charles Gross				Ola Smy		Maiden Sumame)	
Man	C/ 42 12 1		19a. Informant's Name/Relationship (Typ	•					r, City or Town, Stat	
a)	a 0		Charles Pollock (\$ 20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	Place of Dispos semetery, crem	Deer Road Sition (Name of latory or other place L1 Mem. (⁽²⁸⁾ 5/	Date 30	ennsylvani 20c. Location - City	or Town, State
Baltimor	permit. Pag Depertment Important: I any Injury o		21. Signature of Funeral Service License		22. Br	Name and Addre	ss of Facility Ki Funera Eastern A	l Home P	PΑ	ver, Maryland
,	Physician /Medical Examiner		23a. Part1. Enter the disease, or omplie shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Acute Cerev	h. Do not ente	or the mode of dyin	ng, such as cardiac	or respiratory are	M Cypresio	Approximate Interval Between Onset and Death
V ,09/80	tificate be executed g physicien end as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	,					
O. Box	requires that the death certific neen signed by the ettending p hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ ₩6 9 □ Unknown	3c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3 🗆	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year
ř.	w requires that been signed b should be dete	ed by Pl	Part II. Other significant conditions con Hypertension, Ce	tributing to death but not res	A	1		23e. Did to		e to the cause of death? Probably 4 □Unknown
al Kecords	The law ete has b page 2 s	Completed by	Coronary ar	tery disea	5e_			24a. Was a autop: perfor 1 Yes	rned? prior t	autopsy findings available to completion of cause of ?
VItal	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ER/Outpatient	3C DOA Oth	26. Place of Dear			
lon of	ng P Atter t	ı – ,	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun	y at		ence 6 Other (S	pecify)
DIVISION	To the Hospitel or Atlandi within 24 hours effer death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	y) 			City or Tow	n, State)	Rural Route Number,
	e Hosp 24 hou e Fune letely fil	Medicai	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inve	estigation, in my o	ne, data and place pinion, death occur	and due to the c red at the time, d	auea(e) and mailiner ate and place, and o	as stated. lue to the cause(s)
)	To the with n 2 To the complete	¥	29b. Signature and title of certifier			29c. Licens	5629	1	29d. Date signed (Md	
	3		Name and address of person who co	mpleted cause of death (Item	1 23a) (Ty e P		8 0	9	2	2000
	Sta	ite	31. Date filed (Month, Day, Year)	32. Pegistrar's Signa	ture	ON/VIII	Lime	Drive,	Vatto,	Mundo
	Registr	ar	MAY 3 0 200	6	4					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar 1. Decedent's Name (First, Middle, Last)		Cei	tificate of L	Death	2. Date of Deat	eg. No.	0.0	3. Time of Death
Physici /Medic		MARGARET CAROLYN 1	PROESCHER				MAY 25.	2006	Year	10:30 A ^M
Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or			4c. County	of Death	
		1214 WEDDEL AVE.	7 Age (In	land birds day 1	BALTIMOR If Under 1 Year	E If Under 24 Hrs.	O Date of Birth			
Funeral Director		5. Social Security Number 217.38.0987 Usual Residence of Decedent	7. Age (In yrs.	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, OCT. 7,	Year) 1941	9. Birthp Cour	lace (State or Foreign htry) MD
/land		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
Mar.	ctor	MD	BA	LTIMOR	E					1 ☐ Yes 2 ☐ No
or 28	Director	10e. Street and Number		700	10f. Zip Code		1	0g. Citizen of	What Cour	
s 23a	rai	1214 WEDDEL AVE.			21227				ISA	
is 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I the marked other than "natural; or items 23a or 28a-f show other traumatic event, the Modical Exclinitation in this be notified at	by Funeral	11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	2. Was Decedent Ever in L Armed Forces? 1 □ Yes 22 No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2☐ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		ce - Americ ck, White, y: WHI	etc.
72 hc	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa kind of work done d	uring most of work	king	16b. Kind of B		
within ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)			20.11	1215	
buld be filed with Mental Hygiene arked other than atic event, the	ပိ	12 17. Father's Name (First, Middle, Last)		HUM	E MAKER	18. Mother's Nam	e (First, Middle, M	OUH 1		
uld be fental rked c	0	HENRY BEYER				AGNES W	RIGHT			
d 2 s th ar 17 is trau		19a. Informant's Name/Relationship (Type DONALD PROESCHER	pe, Print) HUSBAND		ng Address (Street a					Code)
permit. Pages 1 and Department of Health Important: if item 27 any injury or other tr		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place	a)	Date	20c. Location	City or To	wn, State
Pages ment of h ant: if its ury or o		YBurial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emovar nom State	UDON PA			2006	BALTIN	IORE.	MD
permit Depart Import any inj		21. Signature of Funeral Service License	MO114	F	INK FUNER 26 CRAIN I	AL FROME,	P.A.			
Physician /Medical Examiner		23a. Part i Enter the disease) or complic shock or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Meta 5+AT Due to (or as a consec	ic St				-	2	Approximate Interval Between Onset and Death
ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec							
rtificate be executed ng physician and as the burial-transit	Medical E	L _d		(delice of).						
The law requires that the death cert ate has been signed by the attending page 2 should be detached for use.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2000 Yo 9 Unknown	Bc. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	al death 3	Ectopic pregnancy Other (specify)				te of delive	ry Day Year
equires that	by	Part II. Other significant conditions conf	tributing to death but not res	sulting in the u	nderlying cause give	n in Part I.		acco use con	nbute to th	e cause of death?
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Completed						24a. Was ar autops perform 1 Yes 2	ned?	prior to con death?	osy findings available npletion of cause of 2 No
sicier	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	150/0	t 3 DOA Othe	r	h (Check only one	9)		
Phys eral dii	<u> </u>	27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	JUDON	4 Iduising no	me 5 Reside 28d. Describe ho	w injury occur	er (<i>Specify</i> red	')
ath. r: After ne funera	atio	tXXNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		? 'es 2 □ No		,		
tei or Attendi 's after death. el Director: A	Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	eet, factory, office		28f. Location (Str City or Town	reet and Numb , State)	er or Rura	Route Number,
To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or inv	vestigation, in my op	inion, death occur	and due to the ca red at the time, da	use(s) and ma ite and place,	anner as st and due to	ated. the cause(s)
To To Com	2	29b. Signature and title of certifier	CE MD		D/4	,		Pd. Date signe		
8		30. Name and address of person who cor	repleted cause of death (Item TAGNES	п 23a) (Туре, 900	CATON	AVE I	BALTIC	nore	Mo	21229

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAY 3 0 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 10e 18 19b per fb 9856 6-7-06 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death FATTER SON Month 7 Day **Physician** 12:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 31275 BON SECULIO MUTIMARE 1070 HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of 8 inth (Month, Day, Year) 1-10-1916 5. Social Security Number 6. Sex **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🛣 F 220-14-0280 Director VA Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itams 23a or 28a-f ahov Tre Medical Examinar must be notified at Director 1X Yes 2 □ No MD BALTIMORE 10e. Street and Number 3415 Forest Park Ave 10g. Citizen of What Country? 10f. Zip Code 2553 ARUNAH AVENUE 21216 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 □ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 DOMESTIC HOME is 1 and 2 should be filed in of Health and Mental Hygie fram 27 is marked other other traumatic avant, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evie Coleman WALTER LEE EVE CURRY ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1424 1426 DIVISION ST. BALTIMORE, CHERI THOMAS/NIECE item 27 i MARYLAND 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Punal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Depertment of Important: if any injury or once. MD NATIONAL MEM.PK. 6-1-2006 LAUREL, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEDSIS Physician /Medical Due to (or as a consequence of): Examiner FNEU MONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine MYELOMA physicien and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending physical for use as the b IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atter detached for t 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ COLON CA icete hes been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed PANCY TO PENIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 212 No 1 Yes funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending Natural 5 Pending deeth. investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) monkey no 5/25/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JANET 11. MDGH BF. U. NM. JONE W. ABSTIMME 87, BAGIMME ND 1333 32. Figistrar's Signature 31. Date filed (Month, Day, Year) MAY 3 (

Registrar

State

3 0 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 16839 State of Maryland / Department of Health and Mental Hygiene 0 0 6

Certificate of Death

Physici /Medio Examin	al
Funeral Director	

		Registrar			sen	ilicate c	or Dea	<i>auri</i>		Reg. No.		
Physic	cian	1. Decedent's Name (First, Middle, Las.	=000						2. Date of E	Day	Year	3. Time of Death
/Med		4a. Facility Name (If not institution, give	street and number)			4b, City, Tow	n. or Loca	tion of Dea		40	County of Deal	th
Exam	iner	CHAIG HORING	BAYIGA	/		1201-	me	RE		F	PALTIN	NRG-
Cunava		5. Social Security Number 6. Se		(In yrs. last birth	iday)_	Il Under 1 Ye		nder 24 Hr		irth	9. Birt	thplace (State or Foreign
Funera Directo	_		□ M 200	78 Y	rs.	Months Da	iys Ho	urs Min	Dec.			iaryland
		Usual Residence of Decedent							Dece	0, 10	41	ia± y ±aiia
yland		10a. State 10b. County		10c. City, Town	or Loca	ation						10d. Inside City Limits
Mar B-f	용	Maryland Baltim	ore	Dunda	alk							1 ☐ Yes 2 🔀 No
h the	Director	10e. Street and Number				10f. Zip Cod	de			10g. Citi	zen of What Co	ountry?
death with the Maryland ms 23s or 28s-(show		2031 Bear Ridge Ro	oad, Apt.	1		212	222_			Uni	ted Sta	ites
r dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. W	as Decedent Yes, specify (of Hispan Cuban, Me	ic Origin? (exican, Pue	Specify Yes or North Rican, etc.)	10-	 Race - Ame Black, Whit 	
or it		1 Never Married 2 Married	1 ☐ Yes 2 ☒ ☒ If Yes, Give	Ю	1 (☐ Yes 2🛛	No Sp	ecity:			Specify: Whi	L -
hours at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	10-		- No I be set D						
IIIG X IX 13-0030 be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or Itama 23a or 28a-1 ahow event, it a Madical Examinat must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	de completed)		Give k	ent's Usual Do ind of work do O NOT use re	one during	most of w	orking	160. KI	nd of Business/	industry
withir man	Ē	Elementary/Secondary (0-12)	College (1-4or 5	+)		nemakei	17.			0.44	n Home	
Hygin III.		12 years 17. Father's Name (First, Middle, Last)			пог	llelliake.		Mother's Na	ame (First, Midd			
	9Be	Lewis E. LeBrun					Do	ra Re	einert			
should nd Men market umarket	မှ	19a, Informant's Name/Relationship (7	(vpe. Print)	19b.	Mailing	Address (Str			Rural Route Num	ber. City o	r Town, State, 2	Zip Code)
N 40 = =	1	Mrs. Saundra Jord			_				Apt.			Md. 21222
s 1 and 3 Health ttem 27 other tr		20a. Method of Disposition	ali (Daugi	20b. Place of	Disposi	ition (Name o	f	Tiodo	Date	_	cation - City or	
ages nt of t: If t		1 Burial 2 Cremation 3 4 Donation # Other (Specify		More Lai		atory`or other		5/3	30/2006	Bal	timora	Maryland
Dattimor Dermit. Pages Department of I mportant: If the		21. Signature of meral Service Licen		Moteral	22	Name and Ad	drace of	Facility				
bartimore permit. Pages 1 Department of H Important: If Ita any injury or ot		1 1/2-1 9/	Sill	///	Duc	da-Rucl	k Fur	eral	Home of	Dund	lalk, Ir	nc.
		23a. Part1. Enter the disease, or comp	olications that caused	the death. Do no					Dundalk ac or respiratory		yrand 2	Approximate
		shock, or heart failure. List only of Immediate Cause (Final	one cause on each lin	6.								Interval Between Onset and Death
Physiciai /Medica		disease or condition resulting in death)	a. 501	a consequence o	4).							
Examine			Due to (01 as	a consequence o	1).							
	ē	Sequentially list conditions, if any leading to immediate	b. Due to (or as	a consequence o	f):							
A parsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.									
be executed ician and burial-transit		resulting in death) Last		a consequence o	f):							
68 / 60, Cificate be executed g physician and as the burial-transit	n/Medical		d.									
rtifica ng pt	Med	IF FEMALE:										
SOX Ith cert tendin or use		23b. Was decedent pregnant	23c. If yes, outcome 1☐Live birth	of pregnancy 2 Petal death	3 □€	Ectopic pregna	ancy			2	23d. Date of del Month	
B deat he att	Sici	1 🗆 Yes 2 🗆 No	4 Pregnant at 9 Unknown	time of death	5 🗆	Other (specify	v)				WORK	Day Year
HECOTGS, P.O. BOX 68/ The law requires that the death certificate the has been signed by the attending phys bage 2 should be detached for use as the	Completed by Physicia	9 Unknown				d - 1 - 1		D- 41	220 Die	l tobassa		the saves of death?
S restrigine	<u>ج</u>	Part II. Other significant conditions co		ut not resulting in	tne uni	denying cause	e given in	ranı.			_	o the cause of death? robably 4 □Unknown
w require been si should b) ted	This was	1 Bee	i wat !							5	obably 4 Golikilowii
VITAI KECOFGS, iditan: The law requires t certificate has been signe rector, page 2 should be o	ğ	Casas Hite	sh Ka	2209	,				24a. Wa	is an lopsy formed?	24b. Were at prior to death?	itopsy findings available completion of cause of
	ပိ		-							2 □ N o		2 □ No
ysician: Th ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other		eath Check only	- 11		
OT Physical rations of the control o	မို	1 Tes 2 AO	Impatre	nt 2 ER/Out				☐ Nursing	Home 5 ☐ Re			cify)
on o	o.	27. Manner of Death Natural 5 Pending	28a. Date of Inju (Month, Day	Y Year) 280. In	jury		Injury at Work? 1 Yes	2 □ No	28d. Describ	a now injui	y occurred	
DIVISION Tor Attending after death. Director: Atte	cat	2 Accident investigation 3 Suicide 6 Could not be		ury - At home, lar	m stre				281. Location	(Street an	d Number or Ri	ural Route Number.
LIVISION OF VITA Hospital or Attanding Physician: 14 hours after death. Funeral Director: After this certific fely filled in by the funeral director.	Certification:	4 Homicide determined	building, et	c. (Specify)	, 5410	01, 14001 9, 011				own, State		ar ar riodic realization,
Hospital 14 hours Funeral tely filled			ysician: To the best	of my knowledge,	death	occurred at th	ne time, da	ate and place	ce, and due to th	e cause(s)	and manner as	s stated.
Ho 24 h Fur etely	edicai	(Check only 2 Medical Examona)	niner: On the basis of and manner sta	examination and	Vor inve	estigation, in r	ny opinior	n, death occ	curred at the tim	e, date and	l place, and due	to the cause(s)
DIVI To the Hospital or Al within 24 hours after To the Funeral Direc completely filled in by	₹ S	29b. Signature and title of certifier				29c. Lic	cense nun	nber		29d. Dat	te signed (Mont	h. Day, Year)
- 3 - 0		1 Hammal				RC	5-0	M		CE/	BAR	`
1		30. Name and address of person who	completed cause of d	eath (Item 23a) (Туре, Р	Print)	J			10		MAZZ
5	1	John Hooking	- BOWE	es as	all	loss	(0)	yer	Gar	er R	eral	Ratheren
	State	31. Date filed (Month, Day, Year)	E/	ar's Signature	3846	80				4-1		1
Regi	strar	MAY 3 0 2006	Maria	N. 19	A STATE OF							

			State of Maryland / Department of Health and N State Certificate of Death		jiene	06	16840
	Physici		1. Decedent's Name (First, Middle, Last) Peter A. Petti, Sr.	2. Date of Dea Month		Year 06	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County		-
			Atlantic General Hospital Berlin		Worche	ster	
	Funeral Director		5. Social Security Number 041-10-6523 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day July 19	, 1910	Country	ce (State or Foreign
	and and		Usual Residence of Decedent 10e. City, Town or Location 10a. State 10b. County 10c. City, Town or Location			10d	I. Inside City Limits
	Mary -1 sho	ţō	MD Worchester Berlin				1 Xyes 2 □ No
	th the	lrec	10e. Street and Number 10f. Zip Code	1	log. Citizen of V	_	17
	23a c	la C	1 Meadow Street 21811		U.S.A.		
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other treumetic event. It a Mackel Examinat must be notified at once.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Amarried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Wood If Yes, specify. Cuban, Mexican, Puerforced It Yes, Give To Zates: 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify, Cuban, Mexican, Puerforced) 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Yes, specify. Cuban, Mexican, Puerforced It Yes, Specify.	ecify Yes or No- Rican, etc.)		e - American ck, White, etc Whit	j.
21215-0036	vithln 72 hound.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Bu		,
12	iled w Hygier Iher ti nt. It		4 years Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First Middle	Hardwa		cm
and	d be f ental k ked of	To Be	Ralph Petti Mary Na		maidon baman	.0,	
Maryland	d 2 shoulth and Mark	-	19a. Informant's Name/Relationship (Type, Print) Joan Whitney/Daughter 19b. Mailing Address (Street and Number or Rut 38958 Monroe Avenue, S	ral Route Number			,
Baltimore,	ges 1 an it of Heal if item 2 or other		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location -		
Iţi.	artmer artmer ortant injury			26, 2006			Home, Inc
Ba	Dep Impo		6415 Belair Road,				21206
8760,	The law requires that the death certificate be executed as the last been signed by the attending physician and be detached for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, of conditications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Final Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): c. Due to (or as a consequence of): d.	or respiratory arr	001,	In	pproximate the steven Batween inset and Death
3/06 55 .0. Box 6	it the death certific by the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 5 Other (specify)			te of delivery inth Da	
- 5/2 /34	quires that the solution of th	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to			cause of death?
19/10 - 5/		Completed		24a. Was a autops perform	med2	Were autopsy prior to comp death? 1 \(\sum \text{Yes} \) 2[y findings available detion of cause of
\mathcal{H} /ital	stcian: The certificate h rector, page	Be (examiner?	th (Check only or			
053	Physic this c	은	1 Yes 2 Hospital: 1 Prinpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Ho				
A. 65.20	ding f h. After funer	tion	1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe h	ow injury occurr	red	
Peter Divisi	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Town	treet and Numb n, State)	er or Rural R	Route Number,
2年1	To the Hospital Within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.				
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number 444283	>	29d. Date signed	d (Month, Da	y, Year)
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9733 Houldhure Dro		Berl		n, ()
	St Regist	ate rar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9733 Holl Thury 31. Date filed (Manth Day, Year) 2006 Registrar's Signature				

	1	State of Maryland / Department of Health and I 1- State Registrar Certificate of Death	Mental Hygiene Reg. No	ZIETA INGLE
Physici		Decedent's Name (First, Middle, Last)	2. Date of Death Month Da	3. Time of Death
/Medio Examin		Hedwig Elizabeth Ritterpusch 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	40.	. County of Death
Funeral Director		Manor Care Health Services Rossville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year Hours Min. 214-20-2589 1 □ M 2 □ XF 80 Yrs. Months Days Hours Min.		Baltimore 9. Birthplace (State or Foreign Country) Maryland
Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Essex		10d. Inside City Limits 1 □ Yes 2 🛣 No
DESILITIOTE, INITIALITY ALLE IN 2000 Permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or iteme 23e or 28e-f show importent: If item 27 is marked other than "naturel", or iteme 23e or 28e-f show any injury or other treumatic event, the Medical Examinational be notified at ance.	by Funeral Director	10e. Street and Number 616 North Woodward Drive 11. Marital Status 1□ Never Married 2 Married 3□ Widowed 4□ Divorced 10f. Zip Code 21221 11. Was Decedent Ever in U.S. Armed Forces? 1□ Yes 2 No If Yes, Sive 1□ Yes 2 No If Yes, Sive 1□ Yes 2 No Specify:	U.	S. A. 14. Race - American Indian, Black, White, etc. Specify: White
Mally falled A. I. A. 1. 2. 2000. 10 2 should be filed within 72 hours af the and Mental Hyglene. 27 is marked other than "natural", or treumatic event, the Medical Eabric	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of work interest) (ife. DO NOT use retired) Homemaker	king	(ind of Business/Industry wn Home
should be file and Mental Hy marked oth	To Be (James Klapka Bertha	ne (First, Middle, Maider Albreto Iral Route Number, City	ch
permit. Pages 1 and 2 s Department of Health an Importent: If item 27 is any injury or other treu		Contact Cont	rive Essex	Maryland 21221 ocation City or Town, State Ltimore, Maryland
permit. Departr Importe any inje		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral T407 Old Eastern 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial		ex, Maryland 21221 Approximate Interval Between
bath certificate be executed Exam Altending physicien and attending physicien and for use as the buriat-transit	Ical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any hearing to immediate cause. Enter Underthying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Onset and Death
. 0 0 2	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of delivery Month Day Year
hat hat det			23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
	Completed		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes No
ilon or inding Phy ath. or: After this	Certification; To Be	examiner? 1 Yes 2 No	ath (Check only one) Home 5 ☐ Residence 28d. Describe how inju 28f. Location (Street a City or Town, Stat	ury occurred and Number or Rural Route Number,
LIVIS To the Hospitel or Attervithin 24 hours after det To the Funeral Directo	edical	29a. Certifier (Check crity one) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and plac 2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occ and manner stated.	urred at the time, date an	nd place, and due to the cause(s)
To th Withir To th	W	29b. Signature afficiation of certifier 29c. License number D577 2	-7 29d. Di	ate signed (Month, Day, Year)
	ate	34.037	· Dunda	Wk: an D 21222
Regis	rar	MAY 3 0 2006 Reserve It South		

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ORIGINAL

		-	For State Registrar	State of Maryland		rtment of tificate of			giene Reg. No.	006	16842
	Physicia		Decedent's Name (First, Middle, Last		10			2. Date of Da Month	ath Day	Year	3. Time of Death
	/Medic	al	KOSIE 4a. Facility Name (If not institution, give	Richardso	77	4h Cilv Town	or Location of Deat	May	2+ 4c. (2006 County of Death	
	Examin	er	Union Memor	ial Hospita	21	10 . 11.	nore		NI	A	
	Funeral Director		5. Social Security Number 6. S 210-34-4797 1	T. Age (In yrs. In	Yrs.	If Under 1 Yea Months Days			h Y Year)	9. Birth Con.	place (State or Foreign intry)
	iand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation		-			10d. Inside City Limits
	d within 72 hours after death with the Maryland jiene. I than natural, or Iteme 23e or 28e-f ehow the Madical Examine must be notified at	ctor	MD NA	Ba	ltimor	re					Yes 2 No
	or 28	Funeral Director	10e. Street and Number	01		10f. Zip Code	2.1			zen of What Cou	untry?
	leath v	eral	216 N. Spring	12. Was Decedent Ever in U.S	S. 13. W	as Decedent of	Hispanic Origin? (S	Specify Yes or No	US F	14. Race - Amer	
9	after d or Item		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 No If Yes, Give	If	Yes, specify Cu ☐ Yes 2 No	ban, Mexican, Puer	to Rican, etc.)		Black, White Specify:	, etc.
21215-0036	ural', c	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:						- 51	ac K
15-	in 72 i	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give k	ent's Usual Occi and of work don O NOT use retir	e during most of wo	orking	100. Kir	nd of Business/li	noustry
212	d within giene.	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Home	maker	2		Ho	me	
nd	s 1 and 2 should be filed f Heelth and Mental Hygi Item 27 le marked other other treumatic event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden .	Sumame)	
Maryland	should but marked marked	2	Herbert Jannson 19a. Informant's Name/Relationship		19b. Mailing	a Address (Stree	et and Number or R	ural Route Numb	er, City or	Town, State, Z	ip Code)
	and 2 sho selth and n 27 le m		Thomas Richard		4804		1 0	VW2.584	000000	e, mo	
Baltimore,	iges 1 and it of Heelth it of Heelth 27 or other tr		20a. Method of Disposition	20b. P	ace of Dispos emetery, crem	ition (Name of atory or other p	(ace)	Date	20c. Lo	cation - City or T	Town, State
Ĕ	permit. Pages Depertment of Important: If It any injury or o		4 □ Donation 5 □ Other (Specif	mai		Nationa		3.06	Laur	e1, m	D
Bai	permit. Pag Depertment Important: I eny injury o		21. Signatur, o Funeral)Service Lice		C 0	Name and Add		an Frodh	Itan	Pass Bo	uto,mo 21229
			23a. Party Enterime disease, or com shock or heart failure. List only	plications that caused the death	. Do not ente					70,33	Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	a SEPTIC S	HOCK						24 hours
	/Medical Examiner		resulting in death)	Due to (or as a consequ							7.12
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	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1☐Live birth 2 ☐ Fetal 4☐ Pregnant at time of de 9☐ Unknown		Ectopic pregnar Other (specify)				Month	Day Year
P.0	thet the de led by the detached		9 Unknown Part II. Other significant conditions		ulting in the un	iderlying cause (nven in Part I	23e. Did 1	obacco u	se contribute to	the cause of death?
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ecords,	s been si	ojete						24a. Was		24b. Were au	topsy findings available completion of cause of
α	The lav	Completed						auto perfo 1 ☐ Yes	ormed? 2 No	death?	2 No
of Vital	Physicien: This certificater al director, p	Be	25. Was case referred to medical examiner?	Hospital:				eath (Check only			
of \	d is	- T	1 ☐ Yes 2 MNo 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. In	Other: 4 Nursing	Home 5 Resi			uty)
ion	nding Ph ath. r: After th e funeral	ation	1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year)	Injury	l M	lork? □Yes 2□No				
Division	or Attendi efter death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be determined		ome, farm, stre	et, factory, offic	е	28f. Location (City or To	Street and wn, State	d Number or Ru)	ral Route Number,
_	To the Hospital or Attending within 24 hours efter death. To the Funerel Director: Afte completely filled in by the fune	Medical Co		nysician: To the best of my kno miner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my	y opinion, death occ	curred at the time,	date and	place, and due	to the cause(s)
	To the Vithin To the	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Dat	e signed (Monti	n, Day, Year)
	/		PRusoui	er, M.D	,	AT	243894	16	N	ay 27;	2006
1			30. Name and address of person who		23a) (Type, I	Print)	nse number 243894 Memori	al Cha-	n'L	(, M	0
V)	C+	ate	DANIELA RUS 31. Date filed (Month, Ray, Year)	32. Figistrar's Signa	ture	CONON	· ICONOPI	TL 1705	1 (2	1 ()	
	Regist		31. Date filed (Month, Pay, Year)	2006 Stores.	IS A	men					

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			Please Typ	e or Print i	n Black Inde	indle ink	vaion o		
Omar Rive		R	State of Maryland / [For State egistrar	Department Certificate		d Mental Hy	rgiene Reg. 2. Date of Death	No. 200	6 1 5 8 L ₃
Physic dical Exam			Decedent's Name (First, Middle, Last) Rey Omar Rivera					Day Year D6	1255 hrs
			a Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c County of Deat	h
			1 East Chase Street	lo usa last buthda	Baltimore /) If Under 1 Yea	r If Under 24Hrs.	8 Date of Birth	(MM/DD/YYYY) 9. Bi	rthplace (State or
Funera Directo				In yrs. last birthday 32	Months Day		-	Forei	
			Isual Residence of Decedent	-					
w any		1	0a. State 10b. County 10	City, Town or L Baltimo					10d. Inside City Limits 1 XYes 2 No
yland I-f sho	once	힕.	Oe. Street and Number		10f. Zip Code		10g	Citizen of What Cou	untry?
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with th ns 23a	be not	_ ∟	1. Marital Status 12. Was Decedent Event Armed Forces?	ver in U.S. 13	. Was Decedent of His If Yes, specify Cubar			14. Race - Ame White, etc.	rican Indian, Black,
r death	must	Fu	Never Married 2 X Married 1 Yes 2 X	No 1		specify:		Specify: Wh	ite
us afte ural",	miner	ᇍ	Widowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade complete.	eted) 16a. Dec	edent's Usual Occupa	tion (Give kind of w		6b Kind of Business	/Industry
72 hou m "mat	al Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ng most of working life		ea)	Film	
within jiene	Medic	d L	7. Father's Name (First, Middle, Last)	Via	deo Produc	18.Mother's Name	(First, Middle, Ma		
21215-0036 uld be filed within 7 Mental Hygiene marked other than	nt, the	Š B	Angel Rivera			Maria	Cotto		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mernal Hygiene ment of Health and Mernal Hygiene rent: If item 27 is marked other than "natural", or items 23a or 28a-f sho mart.	matic eve	ᆰ	19a. Informant's Name/Relationship (Type, Print) Allison M. Rivera/ Wife		alling Address (Stree 113 Westvi				
e, N 1 and 2 Health item	r trau	ľ	20a Method of Disposition 1 Burial 2 XCremation 3 Removal from State	acces atom.	sposition (Name of ce or other place)	emetery,	Date	20c Location - City o	r Town, State
Baltimore, bepartment of Her Important: If ite	or othe		Burial 2 XCremation 3 Removal from State 4 Donation 5 Other Specify:	Hillto	Service		27-06	Towson,	Мd.
Baltimo permit Page Department (njury (1	21. Signature of Eureral Service Licensee		22. Name and Addres RUCK TO 1050 Yo	Sof Facility Fune FV Rd To	eral Home	, Inc.	
Physicia	_	-	23a. Part I. Enter the disea e, or a m. cations that caused the	ne death. Do not e	nter the mode of dying	, such as cardiac o	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medica	al	-	failure. List only one ause on each line. Immediate Cause (Final disease a Multiple inj	uries				. <u></u>	Death
Examine	er		or condition resulting in death) Due to (or as a consequence)	uence of):					
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3760 ficate l	s the bi	J/Me	IF FEMALE. 23b. Was decedent pregnant in the 23c. If yes, outcome 1 Live birth	e of pregnancy	Fetal death 3	Ectopic pregna	ancy	23d Date of delive Month	ery Day Year
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be experient 24 hours after death that he errificate has been signed by the attending physician to the functor: After this certificate has been signed by the attending physician	ed for use as the burial	Physician/Medi	past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown		Other (Specify)				
P.O. E	detached	by Ph	Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause	given in Part I.		2 No 3 Pr	to the cause of death?
S, P uires t	ld be d	ed b					24a Was a		autopsy findings available
cord law req has bee	2 should	Completed		<u> </u>			autops perforr	n <u>ed</u> ? death?	
Rec The	r, page		25. Was case referred to medical		26 Plac	ce of Death (Check	1 Yes 2	No 1	Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requiring and ended the area that secrificate has been simplication.	directo	o Be	examiner? 1 ✓ Yes 2 No	nt 2 ER/Outp	atient 3 DOA	Other Nursi	ng Home 5 F	Residence 6 🗸 Oth	er: Scene
of/ ng Phy Vfter th	neral (\vdash	27. Manner of Death 28a. Date of Injur (Month, Day, Ye	y 28b. Tin		jury at Work?	28d. Describe h	ow injury occurred	
sion trendi death ctor:	y the fi	atio	Natural 5 Pending Pending Pnd 5/24/2		12.33 pt	Yes 2 No	28f Location (S	precipitated	Rural Route Number City
Divis	ed in b	Certification:	Suicide S \(\lambda\) Could not be determined (Specify) \(\frac{1}{2}\)	ound on hot	n, street, factory, office	bullding, etc.	or Town, St	ate)1 Fast Cha e, MD (Belve	ase Street Edere Hotel)
[Iospita 4 hour	completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, death	occurred at the time,	date and place, an	d due to the cause	e(s) and manner as st	arted.
o the l Athin 2 A the 1	omplet	Medical	one) 2 Medical Examiner: On the basis of exam and manner stated	nination and/or inv	estigation, in my opinio	on, death occurred	at the time, date a	and place, and due to	the cause(s)
	0	ž	29b. Signature and title of certifier	00		nse number C.M.E.		29d Date signed (A May 25, 2006	nonur, Day, (tal)
		Н	30. Name and address of person who completed cause of de	ath (Item 23a)	_			,,	
-	-			eam (item 23a) ledical Examir	ner 111 Penn S	Street, Baltimo	re, MD 21201		
		tate	31. Date filed (Month, Day, Year) 32. Registrar	's Signature	Bourse &				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 0 6

16844

				Certificate of Death	Reg. No.	
		8	1. Decedent's Name (First, Middle, Last)	2	2. Date of Deeth Month Dey Year	3. Time of Death
	Physicia		Susia S. Rabin	nson	Month Dey Year	415 PM
	/Medic		4a Facility Name (If not institution, give street and number)	4b. City, Town, or Loca		
	Examin	er	Frederick Villa Norsa	no Center Bult	more N/A	
		-	5. Social Security Number 6. Sex 7. Age (In yrs. last b	birthdey) If Under 1 Year If Under 24 Hrs. 8	B. Date of Birth 9. Birt	hplace (State or Foreign
10	Funeral Director		223-28-4245 10M 20F 104	Months Davs Hours Min.	Month, Day, Year) Co	ountry)
	Director	ŀ	Usual Residence of Decedent		1011 by 1701	
	Bud Mar			wn or Location		10d. Inside City Limits
	Aeryl	ō	MD Baltimare	3000 1/0000		1 ⊡√Yes 2 □ No
	the A	9	10e. Street end Number	10f. Zip Code	10g. Citizen of What Co	ountry?
	£ 6	눔	109. Street end Number	7 0515	US	
	ours after death with the Meryland rat, or items 23e or 28e-f show Examiner must be notified at	Be Completed by Funeral Director	1114 Mirga Cincle			
1	igh L	Jue I	11. Mantal Status / 12. Was Decedent Ever in U,S. Armed Forces?	 Was Decedent of Hispenic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri 	ity Yes or No- ican, etc.) 14. Race - Ame Black, White	
0	or h	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Mo	1 ☐ Yes 2 ☐ No Specify:	Specify: A	FAICan
00		ð	3 Noticed 4 □ Divorced Yeer or Dates:		140	nerican
21215-0020	72 hours "natural",	řě	15. Decedent's Education (Specify only highest grade completed)	Se. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/	Industry
21	within ene.	횰	Elementary/Secondary (0-12) College (1-4or 5+)			1 .
	y paragraph of the state of the	į,	3 20	Nursing	170501	tal
pu	should be filad within nd Mantal Hygiene. marked other than imatic event, the Man	Se (17. Father's Neme (First, Middle, Last)		(First, Middle, Maiden Sumame)	/
<u>a</u>	Aanta had by Aanta	P	Sharp Smith	Eli	rabeth Tay,	IOR
Maryland	short in a land		19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Rural I	Route Number, Car or Town, State, 2	Zip Code)
Ž	of the ar		In e Ha Cantes/Daughter	1114 Mirga Cincle	Wood dlawn Mr	70515
a	ges 1 and 2 should be filad within 72 ho t of Haalth and Mantal Hygiene. If Item 27 Is marked other than "natur or other treumatic event, the Medical		20a Method of Disposition 20b. Place	of Disposition (Name of)	Date 20c. Location - City or	Town, State
Baltimore,	permit. Pages 1 and Depertment of Haath Important: If Item 27 any Injury or other ti once.			Buptist Church Cemetery Ju	200 A10	not 1/19
를	permit. Pa Depertmen Important: any Injury once.		4 Donation 5 Other (Specify) Will 18 21. Signature of Funeral Service Licenses	22 Name and Address of Eacility	ne3,204 Merrype	701 11
Ba	permit. P Depertm Importar any Injui		21. Signature of Puneral Service Elections	Har D. Close Fu	menal Service,	P-H
	40240			22. Name and Addr ss of Facility Har Below Roe 5126 Below Roe	ad Baltimore MX	0 21206-5105
			23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not enler the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
A	Physician					Onset and Death
	/Medical		Immediate Cause (Final disease or condition	Denentia		
3.7	Examiner		resulting in death)	a consequence of):		
		ner				
	iceta be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions.	a consequence of.		
oʻ.	exection and and and and and and and and and an	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
68760,	a be /sicia e bu	Cal		a consequence of):		
89	sertificeta be execui ding physician and se es the burial-tran	8	resulting in death) Last			
ŏ	daath certifice attanding ph d for use es t	2	d			
Bo	v raquiras that tha daath o been signed by the attant should be datached for u	Physician	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I	23b. Did tobacco use contribute	to the cause of death?
P.O.	tha d y the ichec	ys	Part II. Other significant conditions contributing to death but not resulting	j iii tile underlying cause given iii i att i.	4	robably 4 Onknown
	that ed by data	=			10 163 20 NO 30 F	obabily 4
ds	raquiras that tha een signed by th hould be datache	d by			24a. Was an autopsy 24b.	Were autopsy findings
9	raqu	e e			performed?	available prior to completion of cause
မ	law es b	힐				of death?
<u> </u>	The law ate hes pega 2:	Completed			1□Yes 2LIN	1 ☐ Yes 2 ☐ No
Division of Vital Records,	icien: The certificate rector, peg	Be (25. Was case referred to medical examiner?	26. Place of Death (
>		2	1 ☐ Yes 2 ☐ Wood Hospital: 1 ☐ Inpatient 2 ☐ ER/6	Outpatient 3 DOA Other: 4 Vursing Home	e 5 ☐ Residence 6 ☐ Other (Spe	cify)
10	g Physer this		(Manth Cay Vans)		8d. Describe how injury occurred	
<u>-'ō</u>	ath. r: After e fune	atio	2 ☐ Accident investigation (Month, Day Year)	M 1 Yes 2 No		
<u>S</u>	Attending Ir death. Octor: Afte by the fune	€	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office 28	Bf. Location (Street and Number or Re City or Town, State)	ural Route Number,
Ö	d Die	Certification:	Sulfailing, 60. (Specify)		ony or rown, oraco,	
	spite	ai	29a. Certifier Sertifying Physician: To the best of my knowled	lge, death occurred at the time, date and place, an	nd due to the cause(s) and manner as	s stated.
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occurred	dat the time, date and place, and due	to the cause(s)
	vithin o th	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont	h, Day, Year)
	- > - 0		Raymond Milli MD	D47683	5/26/06	
	d		The state of the s	o) /Time Print)	100130	
	3	ļ	30. Name and ediffess of person who completed cause of death (Item 236		MA	
		200	Raymond Miller 25 Main Street Son 31. Date filed (Month, Day, Year) 32 Registrer's Signature	ate 200 Kirkshwa	777	
	Sta Registr	100	MAY 3 0 2006	Coarte		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** 26, Anita Roberts 2006 4:50 Bauer May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 9919 Harrogate Road Bethesda If Under 1 Year If Under 24 Hrs. Months Days Hours Min. March 4, 1942 Pennsylvania Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗓 F 64 165-36-0433 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Director Bethesda Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20817 9919 Harrogate Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Institutes and Mental Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) of Health Research Scientist permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louise Evers 2 Max Bauer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9919 Harrogate Road, Bethesda, Maryland 20817 Robert E. Roberts/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 27, 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) 2006 21. Signatury of Furniel Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. Margalatte Burows M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1, or ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Gastric Cancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending physical for use as the t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🕅 No 4 Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 1 ☐ Yes 2 🔀 No has certificate 1 Yes 2 No or Attending Physician: After this certification, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 Yes 2 No death. 2 Accident investigation Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire To the Hospital filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 26, 2006 DC19655 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3800 Reservoir Road, NW., Washington, D.C. 20007-2113 John Marshall, M.D. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 2006 Registrar

		1	For State Registrar	Sta	te of M	larylan		artment			and M	ental Hy	giene	006	16846
Physi	iciar	_	. Decedent's Name (First, Middle MARY JANE		FER							2. Date of De.		2006	3. Time of Death 4:35 FM
/Med Exam	dica	1 -	a. Facility Name (If not institution Saint Josep	give street a	nd numbe	Cent	ter	4b. Cily,	Town, or	Location o	of Death			ounty of Death	
Funera Directo	_		. Social Security Number 169-26-1973	6. Sex	XF 7. A	Age (In yrs.	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bird OCT 3,	931	9. Birth Per	nplace (State or Foreign untry) Insylvania
aryland show			Jsual Residence of Decedent 10a. State 10b. County MD BAL	TIMOR	E	10c. Cit	ty, Town or Lo		E						10d. Inside City Limits 1 Tyes X No
with the M a or 28a-f		5 ž	10e. Street and Number 3519 Old Harf	ord R	oad			10f. Zip	Code	21	1234		10g. Citize	en of What Co	untry?
partitioning in the light of the control of the con		by rur	11. Marital Status 1 ↑ Never Married 2 ↑ Marriad 3 ↑ Widowed 4 ↑ Divorced	ned 1 [s Deceder led Forces Yes 2 [es, Give ar or Dates] No		Was Deced f Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)		. Race - Amer Black, White pecify:	
within 72 hou iene.		Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12)	st grade comp	leted) lege (1-4o	r5+)		dent's Usua kind of wor DO NOT us	rk done di se retired)	u <i>ring m</i> os	it of warki	n <i>g</i>		of Business/l	Decker
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diffillore, rmit. Pages 1 a partment of He portant: If item y injury or oth			20a. Method of Disposition 1 XXurial 2 □ Cremation 4 □ Donation 5 □ Other (S		I from Sta		Place of Dispo			ery		1 – 0 6		fax,P	
permit. Departin	SUC#		21. Signature of Funeral Service	ME	ado	h	88		Harf	ord	Roa			OF M	EMORIES yland 21234
Physicia	n		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one caus	e on each	iline.	th. Do not ent			g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
w requires that the death certificate be executed w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	er	cal Exa	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <u>F</u>	OSS I	BLE as a consecutive as	quence of):	NARY	EMB	OLIS	ЭМ				
C. DOX OB he death certifica the attending ph		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 C 4 C	Live birth	ne of pregn 2 Fet at time of	aldeath 3	□Ectopic pi □ Other (sp		_			23	d. Date of deli Month	ivery Day Year
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2 th 2 th 3 th		Certification:	3 Suicide 6 Could 4 Homicide deterr		. Place of building,	Injury - At I etc. (Spec	home, farm, st	reet, factor	y, office			28f. Location (City or To	Street and wn, State)	Number or Ru	iral Route Number,
Hos Fur Jely		Medical		Examiner: O		s of examig						and due to the red at the time,	date and p	olace, and due	to the cause(s)
To the within 2 To the comple		Σ	29b. Signature and title of certific	1	1		W		c. License D 42	9 number 2736		Promoter to the origination	29d. Date	- 27	h, Day, Year)
10			30. Name and address of person		cause	death (Ite	om 23a) (Type,	Print)	D D	2111		n.ionsi	MAN	ZI ZINITS	21204
Regi	Stat istra		31. Date filed (Month, Day, Year MAY 3		32. Reg	istrar's Sign	Appre 12	WALE.	iv Dř	VIVE	<u>, 16.</u>	WSON,	i i i mirt	I E PHINL	L. 1 E. C. 7

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 16847

	1- For State Certificate of Death							eg. No.	
Physiciar fedical Examin	n/ er	1. Decedent's Name (First, Middle, Last John Henry Sincla	ir Jr.				2 Date of Dea Month May 24, 2	Day Year 006	3. Time of Death 2224 hrs
	1	4a. Facility Name (if not institution, give 19 Goucher Woods Court	street and number)		4b. City, Town Towson	, or Location of	Death	4c. County of Dea Baltimore Co	
Funeral Director			7. Age (In yrs.			Year If Under Days Hours	24Hrs 8. Date of Bir Min. 05/24/	th(MM/DD/YYYY) 9. B Fore 1925	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene Tant: If item 27 is marked other than "natural", or items 23s or other traumatic event, the Medical Examiner, must be not	To Be Completed by Funeral Director	1 X Burial 2 Cremation 3 Removal from State			10f. Zip Cod 212 Was Decedent of f Yes, specify Cu Yes 2 X Jent's Usual Occumost of working	Hispanic Original ban, Mexican, Mospecify: Upation (Give kalife, Do Not call laterated and Number's Least and Number's Road from the complete statement of the complete statem	in? (Specify Yes or No Puerto Rican, etc.) ind of work done use retired) s Name (First, Middle, ena Schmidt ber or Rural Route Nur Frankfo Date 05/30/2006	Og Citizen of What Co U.S.A. 14 Race - Ame White, etc. Specify. Whi 16b. Kind of Business N.A.S.A. Maiden Surname) mber, City or Town, Sta rd, DE 19945 20c. Location - City of Baltimore,	10d. Inside City Limits 1 Yes 2 XNo untry? erican Indian, Black, te s/Industry te, Zip Code) or Town, State Maryland
Physician /Medical Examiner	- 61	Illinodiate odese (i mar areses	ications that caused the dea	th. Do not ente	eonard J. er the mode of dy	Ruck, Ir	ه ما	ford Road e, Maryland 2 rest, shock, or heart	Approximate Interval Between Onset and Death
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	5	cause Enter Underlying Cause	Due to (or as a consequence Due to (or as a consequence AMENDED 23c If yes, outcome of proceeding the content of the conten	egnancy	Fetal death Other (Specify)		pregnancy	23d Date of delive	ery Day Year
Division of Vital Records, P.O. Box 68760, vithin 24 hours after death certificate be executed vithin 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil	Medical Certification: To Be Completed by Physicial	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could not determine 29a. Certifier (Check only one) 2 Medical Examine	contributing to death but no dospital: 1 Inpatient 2 28a. Date of Injury FOUND: Day, Year) On 28a. Place of Injury - A: be	ER/Outpati 28b. Time FOUND: 2200 hrs. home, farm, see	26.F ent 3 DOA of Injury 28c. 1 etreet, factory, off	Place of Death (Other, Injury at Work Yes 2 ce building, etc.	1 _ Ye 24a. Was auto perform the perform one) Nursing Home 5 _ 28d Describe Subject fell or Town, 19 Gouche	Residence 6 Oth how injury occurred down steps Street and Number or F State) r Woods Court, To se(s) and manner as st	autopsy findings available o completion of cause of experiments of the completion of cause of experiments and experiments of the cause (s). Unknown available or cause of experiments of the cause (s).
	Me	29b. Signature and title of certifier 30. Name and address of person who	Completed cause of death (if		0	.C.M.E.	W	29d Date signed (A May 25, 2006	Month, Day, Year)
1	ate	Patricia Aronica-Pollak M 31. Date filed (Month, Day Year) MAY 3 20	3 Registrar's Sign		111 Peni	n Street, Ba	ultimore, MD 2120	J1	

3. Time of Death

29d. Date signed (Month, Day, Year)

Physician	
/Medical	
Examiner	

Funeral Director

or 28a-f show event, the Medical Examiner must be notified at 230 or iteme "natural", s 1 end 2 should be filed within f Health and Mental Hygiene. Item 27 te marked other then permit. Pages 1
Depertment of He
Important: If iten
eny injury or oth

Maryland 21215-0036

Baltimore,

2006

Physician /Medical **Examiner**

P.O. Box 68760. Records, hes of Vital

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the death certificate be executed burial-transit and signed by the attending physician d be detached for use as the buria been s this certificete Director: After that in by the funeral death. after To the Hospital within 24 hours a To the Funeral Completely filled

2000 10:20pм Smith May 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Baltimore Stella Maris Hospice Towson Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 VA 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Days Hours Min 1 ☐ M 2 🖫 F 97 Yrs 051-10-8507 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore MD NA 1 Xes 2 No Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 3805 Cedardale Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 TNo Specify: Specify: Black Completed by 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Clerk 12th grade lyr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Annie James Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 741 Van Siclen Ave, Brooklyn, NY 11207 Sharon Lewis-Grand-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Baltimore National 6-1-06 Balto., Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Eig ature of Funeral Se 21215 Baltimore, Md 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition END STAGE RENAL DISEASE resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 1 Yes 2K No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DR. TARIQ MAHMOOD

MAY 3 0 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

2300 DULANEY VALLEY RD.

29c. License number

43725

TIMONIUM, MD 21093

				State of Marylar	nd / Departme	ent of Health and	Mental Hygie	ne o o o	15010
		•	For State Registrar	,	•	ate of Death	Reg.	711116	16849
	Physici		1. Decedent's Name (First, Middle, L	Star Kes			2. Date of Death Month	Day Year	3. Time of Death 1235 DM
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)	1 46.0	City, Town, or Location of De	ath A. T.	4c. County of Death	
	1 / W	4	Maryland	General He	spital B	OLTMURE nder 1 Year If Under 24 Hi	Cryg	NA	alone (Otano a Caralan
	Funeral Director		5. Social Security Number 6. 217-70-1493	Sex 7. Age (In yrs 1 M 2 F 4 Q	Yrs. Mont			ar) Gould	place (State or Foreign intry)
			Usual Residence of Decedent	100			1,000,000	11011	
2	show	or	10a. State 10b. County		ity, Town or Location				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
with the Maryland	28a-	Director	10e. Street and Number	1/14	Sultimo 10%.	Zip Code	10g.	Citizen of What Cou	intry?
£	ral', or iteme 23a or 28a-f show Examiner must be notilized at	alD	2805 W.V	nulberry S	×+.	21217		USA	
	teme per ma	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was De If Yes,	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - American Black, White,	
36	o'.	by F	1 PNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 102 No If Yes, Give Year or Dates:	1 □ Ye	s 2 Specify:		Specify: AF	
5-06	natural, or iteme 23s	eted	15. Decedent's (Specify only highest g	Education trade completed)	16a. Decedent's U	Jsual Occupation f work done during most of w	rorking 16b	. Kind of Business/In	enticing
121		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	/	work done during most of w T use retired)		Const	n. 1. Los
d 22	Hygie other t		17. Father's Name (First, Middle, Las	st)		18. Mother's N	ame (First, Middle, Maid		waray
/land	nd Mental Hygi marked other matic event, I	To Be	Frank. Sta	vkes			Fannie L	3. Star	rkes
	2 2 2		19a. Informant's Name/Relationship	Y	_	ress (Street and Number or I		A LANGUIN CO.	
70) e, N	f Health item 27 other tr		20a. Method of Disposition	ience /Sister	Place of Disposition (Name of	Date St.	Sulffer re	own, State
Z ou	ant of y or o		1 Burial 2 Teremation 3 4 Donation 5 Other (Spec		Cometery, crematory	or other place) Cinematory Ma	/		Re, MD
Amaltim	Department of important: If any injury or once.		21. Signature of Funeral Service Lic						
~ 8	Depa Impo					5126 B	elark Road	Baltem	P. A. M. M. M. M. M. M. M. M. M. M. M. M. M.
50g			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the dealy one cause on each line.	th. Do not enter the r	mode of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ventricu	TUR H	RRNYTTIIII	Z		
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Вох	attendi for use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1□Live birth 2 □ Fet 4□Pregnant at time of	tal death 3 □Ectopi	ic pregnancy		23d. Date of delive Month	ery Day Year
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	been signed by the attending physician and should be detached for use as the burial-transit	by PI	Part II. Other significant conditions	contributing to death but not re	sulting in the underlying	ng cause given in Part I.		co use contribute to t	/
ord	bluod	eted					-	2 No 3 Prot	
Division of Vital Records,	has e 2	Completed				<u> </u>	24a. Was an autopsy performed	? death?	opsy findings available ompletion of cause of
tal		a	25. Was case referred to medical			26. Place of D	1 ☐ Yes 2 ☐ eath (Check only one)	No 1 □ Yes	2 No
of Vita	s p	To B	examiner? 1 ☑ Yes 2 ☐ No		ER/Outpatient 3	Other	Home 5 ☐ Residence	6 ☐Other (Special	fy)
0 10	th. : After this certifical funeral director, p		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	njury occurred	
risic	death ctor: y the	flcat	2 Accident investigat 3 Suicide 6 Could not	be Ogo Blace of Injury At I	home, farm, street, fac	1 Yes 2 No		and Number or Rura	al Route Number,
o j	s after si Dire	Certification:	4 Homicide determine	building, etc. (Spec	eify)		City or Town, St	ate)	
3	within 2 rospites or an entire death. To the Funeral Director: After it completely filled in by the funeral	edlcal (29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my kn aminur: On the basis of examin and manner stated.	nowledge, death occur nation and/or investiga	red at the time, date and pla tion, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as s and place, and due to	stated. o the cause(s)
	To th comple	Me	29b. Signature and title of certifier	11		29c. License number	29d.	Date signed (Month,	Day, Year)
) A	1		101X-10H	tal M		1)5(6)5	14	94142	006
2	_ '		30. The and stress son	co let cause of death (Ite	m 23a) (Type, Print)	DS(6)5 d General	Hospital	d	
000	Sta	ate	31. Date fielt (Month, Day, 1964)	32. Registrar's Sign	nature) [W]		1,100		
	Regist	rar	MAY 3 0	2006	18 Anne	E. D			

		1 - For State Registrar	State of Mary		artment of F rtificate of			iene 2006	16850
Physic /Med		Decedent's Name (First, Middle SIMM		S	CHMIDT		2. Date of Dea Month MAY 2	7, Day 2006 Year	3. Time of Death 6:15 A M
Exam		4a. Facility Name (If not institution 5 LEICESTER CO			4b. City, Town, o	OWINGS		4c. County of Death	BALTIMORE
Funera Directo		5. Social Security Number 212-30-7623		yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hr		1933 9. Birth	place (State or Foreign ntry) MD
ehow	J.	Usual Residence of Decedent 10a. State 10b. County MD BA	LTIMORE 10c	c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
ith the Marylar or 28a-f ehow	Director	10e. Street and Number	LITHORE	DALII	10f. Zip Code		1	0g. Citizen of What Cou	
ath wit	raiD	21 GREENWICH P		:- 11.0	1W D	21208	Casada Van an Na	14 Page Amer	USA
72 hours after death w naturel', or items 23a	by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 💢 No		Specify Yes or No- rto Rican, etc.)	14. Race - Amen Black, White, Specify:	
	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo d) SALES		16b. Kind of Business/Ir	SUPPLY
lal y lailu Z I Z 2 should be filed within and Mental Hygiene. Ie marked other than eumatic event, the M.	Be Co	17. Father's Name (First, Middle,	Last)			,	me (First, Middle, I		
should be nd Mental marked o	TO B	JACK		ROSEN		JEANN			LEVIN
y, INIGII		19a. Informant's Name/Relations ROBIN WALKER /						r, City or Town, State, Zij LLS,MD 211	
Pages 1 and the total of Height of H		20a. Method of Disposition 1 🕱 Burial 2 🗀 Cremation	3 DRemoval from State		matory or other pla	,		20c. Location - City or To	
permit. Pages 1 and 2 Department of Health a Important: If item 27 is	a	4 Donation 5 Other (S			AEL CEME		/29/2006	BALTIMORE ON & BROS.,	
	ä	Rocato	The state of the s					IKESVILLE,	
Physiciar /Medica		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each line. ametast	tatic v	,			cancer	Approximate Interval Between Onset and Death
Examine	_	Sequentially list conditions	Due to (or as a con	nsequence or):					•
pet led	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of):					
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cate be ex physicien s the buria	dicai	Á	d			-			
The Coll day, T.C. DOX 00100, The law requires that the death certificate be executed at each signed by the attending physicien and page 2 should be detached for use as the burial-transit	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of deliv Month	ery Day Year
requires that the en signed by nould be detact	by P	Part II. Other significant condition	ons contributing to death but no	t resulting in the u	inderlying cause gr	ven in Part I.		bacco use contribute to t	N 2
The law recate has bee page 2 short	Completed						24a. Was a autops perform	ned? death?	opsy findings available impletion of cause of
vician: sician: certifica rector, p	Be	25. Was case referred to medical examiner?	Hoepital:		Ott	ner	ath Check only on	0	DAHOUTEDIO
ig Physical dispersion	n: To	1 ☐ Yes 2 Ø No 27. Manner of Death	28a. Date of Injury	2 ER/Outpaties 28b. Time of Injury	IL SELDON	4 🗆 Nursing		ence 6 Other (Special ow injury occurred	DAUGHTER'S
To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the tuneral director, page 2	Certification:	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could 4 Homicide determ	not be ass Place of Injury	At home, farm, st	M 1	Yes 2□No	28f. Location (St City or Town	reet and Number or Rura n, State)	al Route Number,
Hospitel 24 hours a Funerel (edical Ce	29a. Certifier 11 Certifyin (Check only one) Medical	ng Physician: To the best of my Examiner: On the basis of exa and manner stated.	r knowledge, deat mination and/or in	h occurred at the trivestigation, in my c	me, date and place opinion, death occ	e, and due to the courred at the time, d	ause s and manner as s ate and place, and due to	tated the cause(s)
To th within To th	Me	29b. Signature and title of certifie	rulde r	110	29c. Licens	se number 10589	47	9d. Date signed (<i>Month</i> , 5 27 06	Day, Year)
10 '		Nancy Vand	who completed cause of death	1D 24	Print) WB	elveder	e Balt	MD alal	5
Regis	State strar	31. Date filed (Month, Day, Year)	32. Registrar's S	dignature doa	de				

		_		State of Man	yland / De		t of He	ealth ar		ntal Hygi	ene g. No.	06	16851
	Dhuaini		1. Decedent's Name (First, Middle, Last)						2	Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic	al	KAREN			SCHIF			Darath	May	26	2006 by of Death	(D: 25 AM
	Examin	er	4a. Facility Name (If not institution, give si LEVINDALE HEBREW I	HOME		BAI	Town, or L	RE			46. Count		N/A
E	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (I	n yrs. last birtho	Months		Hours	Min.	Date of Birth (Month, Day, 10/24/	1953	9. Birthp Coun	lace (State or Foreign try) MD
7	aud W		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town o	or Location						1	Od. Inside City Limits
	Maryl Ista	tor	MD BALTII	MORE	BAL	TIMORE							1 ☐ Yes 2 No
4	with the	Director	10e. Street and Number 3413 JO ANN DRIV	=		10f. Zi	Code	2	1244	10	g. Citizen of	What Cour	try? USA
1	ms 2;	Funeral		2. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dece If Yes, spe	dent of His	panic Origi	in? (Speci	fy Yes or No-		ice - Americ ack, White,	
036	be filed within 72 hours after death with the Maryland thygiene. Hygiene. d other then "naturel", or items 23e or 28e-f show event, I're Mooreal Examination usites notified at	by	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 XX No If Yes, Give Year or Dates:		1 ☐ Yes		Specify:	1 4010 11	July 510.7	Spec		WHITE
ָרָ ה	72 ho	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. D	ecedent's Usu Give kind of wo ife. DO NOT L	al Occupati ork done du	ion iring most	of working	1	6b. Kind of	Business/Ind	dustry
1212	within iene. r then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		A PROC					BANKI	NG	
⊆ .	e d la be	To Be C	17. Father's Name (First, Middle, Last) ALAN		GRO	SS	1		's Name (QUEL	First, Middle, M	laiden Suma	me)	TAUB
Mary	d 2 should th and Men 7 Is marke traumatic		19a. Informant's Name/Relationship (Type ALAN GROSS / FATH			-				Route Number, TIMORE,			Code)
<u>6</u>	s 1 and f Health item 27 other tr		20a. Method of Disposition		20b. Place of D				Dat		Oc. Location		wn, State
Ë .	Page: nent o ant: If any or		1 Burial 2 □ Cremation 3 □ Re 1 Donation 5 □ Other (Specify)		ARLINGT				5/26	5/06	BALTI	MORE,	MD
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 eny injury or other 2005.		21. Signature of Funeral Serv. e License	2		22. Name a			JUL	LEVINS			INC. MD 21208
			23a. Part1 Enter the disease, or complice shock, or heart failure. List only on	cations that caused the cause on each line.	e death. Do no	t enter the mo	de of dying,	, such as c	ardiac or i	respiratory arre	st,		Approximate Interval Between Onset and Death
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о П	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physiclan/Med	in the past 12 months? 1 □ Yes 2 DNo 9 □ Unknown	4☐Pregnant at tin 9☐Unknown		5 Other (s	pecify)					Ontri	Day 10ai
s, P.O	ss that the gned by se detac	by Ph	Part II. Other significant conditions con	tributing to death but	not resulting in t	the underlying	cause giver	n in Part I.			1.77		ne cause of death?
ord	w requires that been signed k should be deta	eted								1 🗆 Ye	-20		ably 4 Unknown
Records,	The la	Completed								24a. Was ar autopsy perform 1 Yes 2	/	prior to con death?	psy findings available inpletion of cause of
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of	Physi r this c ral din	- To	1 ☐ Yes 2 🗖 No 27. Manner of D at	28a. D. e f Injury	28b. Tir		28c. Injury Work	4 1901		e 5 Reside			y)
0	Attending Physicien: ir death. ector: After this certifica by the funeral director, p	atlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	(ear) Inj	ury M		? es 2 □ N	lo				
Division of	of or Attendated after death	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	r - At home, farn (Specify)	n, street, facto	ry, office		28	f. Location (Sti City or Town		nber or Rura	i Route Number,
	To the Hospitel or Attending Physicien: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C		sicien: To the best of e ner: On the basis of e and manner state	xamination and								
	To the within 2 To the comple	Med	29b. Signature and title of certifier *	and manner state		29	c. License	number		29	d. Date sign	ned (Month).	Day, Year)
}	-s+ō		A. Muzuo	mi, Mg			D 00	0601	70		5/	26/	2006
1	D		30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (T	ype, Print)					1	t	
		ate	31. Date filed (Month, Day, Year)		s Signature	1 .							
	Regist		MAY 3 0 200	6 Bolon	, J.	Coarle	,						

State of Maryland / Department of Health and Mental Hygiene 16852 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 28, 12:29 PM 2006 May Tummala Suryanarayana /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, NOV . 5, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1940 India 1 X M 2 □ F 65 407-82-1050 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Eventure. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 Yes 2 No Silver Spring Directo Montgomery Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20905 16921 Harbortown Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 21X Married 1 ☐ Yes 2X No Specify: Specify: Asian-Indian þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Physician Medical 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname, Be Tummala Narasaiah Mahalakshmi Gondi ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16921 Harbortown Drive, Silver Spring, MD 20905 Nirmala Narla/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 29, 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 2006 Montgomery Crematorium Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. William U. tunstney M01173 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hyper Kalema **Physician** 30 minutes /Medical Due to (or as a consequence of) Examiner Failure 3 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events Due to (or as a consequence of): Examiner moscleros 15 The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 PYes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 252 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Enpatient ို 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 52119 may 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Suite 302; 8100 GOODLUCKED; CHATRATHI FRIDHAR 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 3 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 27**,** 2006 Marian Clare Thomas Ам 8:15 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Stella Maris Hospice Center Timonium | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Min. | March | 26, 1929 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 77 216 58 4195 Yrs. New York Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exact must be notified at once. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 ☐ Yes 2√2 No Director Maryland Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21085 USA 1402 Brierwood Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done d life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Josephine Sclavi Peter Mezzadri 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1402 Brierwood Ct. Joppa, Maryland 21085 Joan Groszkowski (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/29/2006 Bayview Crematory Baltimore, Maryland ' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Bruzdzinski funeral Home P.A. ohn W. 1407 Old Eastern Avenue Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Cervica Immediate Cause (Final Metostore Mo. Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Year ŏ Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page certificate 1 ☐ Yes 2 🗆 🗤 or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Rell 1. Mon 30. Name and address of person who completed cause of death (Item 23a) (Typg, Print) 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month 2:40 **Physician** Viola Thornton Ü /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Loch Raven Center Baltimore 8. Date of Birth (Month, Day, Year) Choher 10,1909 Birthplace (State or Foreign Country)
 Virginia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Months 1□M 2\F Days 96 212-16-5043 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland h and Mental Hygiene. 7 is marked other than "naturel", or Items 23a or 28a-f shov treumatic event, the Medical Exart is activate the notified at Yes 2 No Maryland N/A Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1102 Druid Hill Ave. Apt.802 21201 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th College (1-4or 5+) n/a Domestic House Keeping House Keeping 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Henry Evans Martha Green ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 Is any injury or other tree once. Mrs. Grace Tabb (Daughter) 1711 E. Belvedere Ave. Baltimore, Maryland 21239 Baltimore, 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Evans Funeral Chapel Forest Hill, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur, o Funeral Service Liceraee 22. Name and Address of Facility reaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 Part . Enfer the disease, or com shock, or heart fallure. List only ohs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Complica nlumonia Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ emen Da 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 200 No certificate 1 Yes 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🜠 No 2 2 ER/Outpatient 3 DOA Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation M 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel I 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type,

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8 1	- JA . 15		1. Decedent's Name (First, Middle, Last)		-			2. Date of D Month	Day	3. Time of Death
	ysicia Aedic	al -	Willard Patrick					MAY	18,2006	2340 M
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satt j			5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday	If Under 1 Year	If Onder 24 H	Irs. 8. Date of 8		9. Birthplace (State or Foreign
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Nem 27 is marked other then "natural", or items 23e or 28e-1 show	TONIS	Funeral Directo		2. Was Decedent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or N	lo- 14. Race	- American Indian,
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21215-0036 ad within 72 hours af rgiene. er then "natural", or	Exa	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates: 194	15	1 ☐ Yes 2X No	Specify:		Specify:	WILLCE
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Baltimore, bermit. Pages 1 ar Department of Hea mportant: If Item	r oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re		cemetery, cre	osition (Name of matory or other place	oe)	Date	20c. Location - C	City or Town, State
timor Pages tment of I	jury		4 □Donation 5 □ Other (Specify)	Sta	Park	Memorial		25/06		, Virginia
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		-	23a. Part1. Enter the disease, or complic	cations that caused the dea				Ties -	ridge, VA	Approximate
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Physic /Med			disease or condition resulting in death)	Motor Ve	ne de	. Accid.	ed un	h Mull	if the try	wiles.
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of Vital Records, Physician: The law requires trinis certificate has been signs	should be det		BIATA CHAC	4		·		_ 10	Yes 2 No 3	3 ☐ Probably 4 ☐ Unknown
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Of \ Physi this o	al dir	2	1 ☐ Yes 2 ☐ No ☐' 27. Manner of Death		ER/Outpatie	nt 3 DOA Oth	4 🗆 (40/3)//(sidence 6 Other	
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Division of Attending after death. Director: After	y the	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, st			28f Location	(Street and Number	r or Bural Boute Number
Div	d in b	erti	4 Homicide	building, etc. (Speci	51	reel		City or To	own, State) EAS	ren chipel
Div To the Hospital or A within 24 hours after To the Funeral Dirs	completely filled in by the funeral director,	edical C	(Check only 2 Medical Examin	ician: To the best of my kn er: On the basis of examin	owledge, deal	th occurred at the time	me, date and pla	ace, and due to the	e cause(s) and man	ner as stated. Rund
the hin 2	mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c, Licens				ATTSVILLE, Ma.
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	7		30. Name and address of person who con		m 23a) /T	Print)	00337	+1	my hi	2006
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with the Maryland r then "naturel", or items 23e or 28a-f eho the Madical Examiner must be notified at Director 10f. Zip Code 1024 Jack Place 21225 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cashier permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importent: If Item 27 is marked other eny lighty or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jerome Meyd Peggy North ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerome F. Meyd (father) 7575 E Howard Road, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 21. Signature of Funer Service Licenses 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pa<u>sadena, MD 21122</u> complinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only or cause on each line. 23a. Part1. Enter the disease, or compli-shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Cancer ung Physician /Medical Due to (or as a cons quence of): Examiner Sequentially list conditions, if any, leading to intribulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of). IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23b. Was decedent pregnant in the past 12 pronths? 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No Completed andenh Werk 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ 1√0 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient ٩ 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

and manner stated

brotham

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

I. Decedent's Name (First, Middle, Last)

Sociat

5. Social Security Number

214-62-1454

Maryland

10e. Street and Number

10a, State

Usual Residence of Decedent

Μ.

4a. Facility Name (If not institution, give street and number

10b. County

Vandenhuerk

7. Age (In yrs. last birthday)

52

10c. City, Town or Location

Agnes

1 ☐ M 2 💢 F

Physician

/Medical

Examiner

Funeral

Director

State of Maryland / Department of Health and Mental Hygien® | | Certificate of Death

4b. City, Town, or Location of Death

Baltimore

Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, June 29

Reg. No.

Specify:

2. Date of Death

May

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3. Time of Death 18:43 PM 2006 4c. County of Death N/A Birthplace (State or Foreign Country) 10d. Inside City Limits 1X Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. White 16b. Kind of Business/Industry Food Service 20c. Location - City or Town, State Baltimore, Maryland Approximate Interval Between Onset and Death year 23d. Date of delivery Month Year Dav 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Dev. Year)

DHMH 17 Rev 1/200

Medical

State

Registrar

(Check only one)

29b. Signature and title of certifier

30. Name and address of perso

31. Date filed (Month, Day, Year)

2 aurie

3 0 2006

900

29c. License number

Ave, Baltimore, MD

			For State Registrar	State of Marylan	-	nent of He			iene 2006	16857
	Physici		Decedent's Name (First, Middle, Last) William	т.	Vog	ge1		2. Date of Deat Month		3. Time of Death
	/Medie Examir Funeral Director		4a. Facility Name (If not institution, give Franklin Square 5. Social Security Number 6.	Hospital Cen	HC last birthday) If	City, Town, or 1	ocation of Death Ocation of Death If Under 24 Hrs. Hours Min.		4c. County of Dea	
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Md. Balti		ity, Town or Location					10d. Inside City Limits 1 □ Yes 2 □ No
	with the 3a or 28a	I Director	10e. Street and Number 5907 Shady Spr	ing Avenue	1	Of. Zip Code 21237	7-2025	1	0g. Citizen of What C	ountry?
36	irs after deeth	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Wildowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Decedent of His s, specify Cuban Yes 2 No	panic Origin? (Sp., Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Ame Black, Whit Specify: W	
21215-0036	be filed within 72 hours after deeth with the Maryland ital Hygiene. d other then "natural", or iteme 23e or 28e-f ehow event, its Medical Exaction crossible notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary(Secondary (0-12)	cation	(Give kind	IOT use retired)	iring most of wor	king	16b. Kind of Business	Andustry Can Com.
Maryland 2	2 should be filed withir and Mental Hygiene. Ie marked other then eumatic event, the Ma	To Be C	17. Father's Name (First, Middle, Last) William Vogel 19a. Informant's Name/Relationship (Ty	no Print	10h Mailion A		Margar		Maiden Sumame) anowski City or Town, State.	7- 0-41
Baltimore, Mar	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 le marke eny injury or other treumatic once.		Trilby Tancibok 20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	(daughter) lemoval from State	5907 S Place of Disposition cemetery, cremator	Shady S n (Name of ry or other place)	Spring	Ave. Ro	sedale, M 20c. Location - City or	d.21237 Town, State
Baltir	permit. P Departme Importan eny injur.		21. Signature of Funeral Service Licens		22. Na	me and Address	of Facilit Kac	zorowsk	altimore i Funera imore, M	1 Home, PA
8760,	cate be executed Wedician and Chysicien and Chys	dicai Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of	quence of): Ar ter quence of):	farct y Disec				Iniérval Between Onset and Death
P.O. Box 68	ath certific thending p or use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □Ecto	opic pregnancy er (specify)			23d. Date of de Month	livery Day Year
	w requires that the debeen signed by the a should be detached f		Part II. Other significant conditions con	ntributing to death but not re	sulting in the under		n in Part I.		s 2 No 3 P	the cause of death?
al Reco	ician: The law requ certificete hes been ector, page 2 should	Completed by				1		24a. Was ar autopsy perform 1 Yes 2	ned? death?	utopsy findings available completion of cause of 2 No
Division of Vital Records,	Phys	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 npatient 2 2 28a. Date of Injury (Month, Day Year)	2 ER/Outpatient 3 DOA Other: 4 Nursing Homesear) 28b. Time of Injury M 1 Yes 2 No				cify)	
Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, i	actory, office		28f. Location (Str. City or Town	reet and Number or Ri State)	ural Route Number,
	ne Hospit n 24 hour ne Funera	Medicai	29a. Certifier (Cneck only one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (Cneck one) 1 V Certifying Physical Examination (sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death occ ation and/or investig	curred at the time gation, in my opi	, date and place, nion, death occur	and due to the ca red at the time, da	use(s) and manner as ate and place, and due	s stated. to the cause(s)
	To the comp	Σ	29b. Signature and title of certifier	te		129c. License			9d. Date signed (Mont 5/24/06	
	21		30. Name an 1 dress of person who co	mpleted cause of death (Ite Winter 90	m 23a) (Type, Print	Sin Sai	Lace Dr	ve Ral	5/24/06 fimore, Md	21237
	Sta Registi		31. Date filed (Month, Day, Year) MAY 3 0 20	32. Hegistrar's Sign	ature from	E .				

			1 - For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of H tificate of L			giene Reg. No.	006	16858			
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Catherine S. Wilde	erson				2. Date of De Month May	ath Day	2006	3. Time of Death 4:40 A M			
- 10	Examir		4a. Facility Name (If not institution, give s St. Agnes Hospita	J		ounty of Death								
	Funeral Director		210 11 1100	M 2 F 7. A	ge (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	8. Date of Bir (Month, Da June 12	th y, Year) 192	9. Birthpl Coun 3 Mary1	ace (State or Foreign try) and				
	he Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Anne Arun	ıde1	10c. City, Town or Lo					10d. Inside C				
	with ti	Dir	10e. Street and Number 7144 Baltimore Ann	anolis R	1vd	10f. Zip Code 21061			U.S.A	n of What Coun	try?			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mudical Evals from shall be sufficed at ODEs.	by Funerai		2. Was Decedent Armed Forces 1 Tyes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13. Y	Was Decedent of Hi 1 Yes, specify Cuba 1 ☐ Yes 2 ☑ No	pecify Yes or No Plican, etc.)	- 14						
21215-0036	d within 72 ho piene. in then "naturi ine Maccal I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		Mary1	16b. Kind of Business/Industry Maryland Department of Motor Vehicles								
Maryland	ild be file lental Hyg ked othe	To Be C	17. Father's Name (First, Middle, Last) Michael A. Murphy				18. Mother's Nam		e (First, Middle, Maiden Surname)					
Mary	id 2 shou ith and M 27 is mar traumat	-	19a. Informant's Name/Relationship (Typ. Jeffrey M. Wilders			ng Address (Street a					·			
Baltimore,	Pages 1 annent of Heal int: # Item?		Jeffrey M. Wilderson/ Son 7144 Baltimore Annapolis Blvd Ferndale MD 21061 20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Application 5 Other (Specify) Meadowridge Memorial June 1, 2006 Elkridge, MD											
Balti	permit. Departn Imports eny inju		21. Figrature of Funeral Service License	Dalla	GOV 122	Name and Address Tu Mbrose Fu 328 Sulph	is of Facility Ineral Ho Iur Sprin	me, Inc g Rd. A	rbutu	s MD 21:	227			
100	Physician		23a. Part. Enter the disease, of complications that caused the death. Po not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition as the cause of the											
8760,	Medical Examiner bhysicien and bhysicien and sthe burial-transit	Physician/Medical Examiner	Sequentially list conditions. If any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (cr as	A cut rensequence of the sa consequence of t	al failu ract infec	re hom							
.O. Box 6	The faw requires that the death certifi ate has been signed by the attending page 2 should be detached for use as		hysician/Me	hysician/Me	hysician/Me	nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			230	d. Date of delive Month
rds, P	quires that n signed b	by	Part II. Other significant conditions con Chronic atrial	tributing to death I		nderlying cause give	en in Part I.	23e. Did t			e cause of death?			
Division of Vital Records, P.O. Box	iician: The faw requir certificate has been si rector, page 2 should I	Completed	Hypertension					autor perfo	autopsy prior to com performed? death?		osy findings available apletion of cause of			
<u>=</u>	ysiciar is certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ent 2 TER/Outnation	Othe	26. Place of Deat			Other (Secure				
ion of	ading Phy th. : After this e funeral c		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ 4 ☐ N 28a. Date of Injury (Month, Day Year) ☐ 28b. Time of Injury Mork? M 1 ☐ Yes 2 ☐ H. Time of Injury Mork?				ne 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			,			
Divis	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Rou City or Town, State)											
	he Hospi n 24 hou he Funer pletely fill	edicai	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier P	ician: To the best er: On the basis of and manner si	of my knowledge, death of examination and/or inv tated.	occurred at the time restigation, in my op	e, date and place, pinion, death occur	and due to the red at the time,	cause(s) ar date and pl	nd manner as sta ace, and due to	ated. the cause(s)			
١	To the Committee of the	Σ	29b. Signature and title of certifier Bichhung	1. 9inh		29c. License			29d. Date signed (Month, Dey, Year) May 29, 2006					
5	1		Dich huny 10 30. Name and address of per n who co Bichhuong M. T	mpleted cause of	death (Item 23a) (Type.	ton Ave,	Box #60	, Balti	more	,M9 2	1229			
100	- Sta Registi		31. Date filed (Month, Da), Year) MAY 3 0 2006	32. Regist	rar's Signature									

			For State Registrar	State of M	larylan		artmen tificate			and M		giene Reg. No.	06	16859
	1. Decedent's Name (First, Middle, Last) Physician						MEINED					ath	O Kear	3. Time of Death 10:00 P M
	/Medio	cal	SALLYE 4a. Facility Name (If not institution, gin	•)	WEINER 4b. City, Town, or Location of Death					MAY 25, 2006				
	Examir	ler	FUTURE CARE					BALTIMORE						N/A
95.	Funeral Director		214-16-5246	Sex 7. A 1 □ M 2 ☑ F	ge (In yrs. 8	ast birthday) 7 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birtl Month Pay 08/22/	7918	9. Birth Cou	place (State or Foreign ntry) MD
	ow ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	e Mary	ctor	MD N/A			BALTII	MORE							1 X Yes 2 □ No
	with th	Funeral Director	10e. Street and Number	_			10f. Zip		21207			10g. Citizen of		ntry? SA
	ne 23	erai	4800 SETON DRIV	12. Was Deceden	t Ever in U.	.S. 13.	Was Deced				cify Yes or No- Rican, etc.)	14. Ra	ce - Ameri	can Indian,
36	72 hours after death with the Maryland Inatural', or Iteme 23a or 28a-f show dreal Exercine must be rediffed at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces 1 Yes 2 X If Yes, Give Year or Dates	No		r Yes, spec 1 ☐ Yes 2		n, Mexican Specify:	, Puerto I	Hican, etc.)	Speci	ick, White, fy:	WHITE
5-0036	72 hou		15. Decedent's E (Specify only highest gr			16a. Deced			ation during most	of workii	na	16b. Kind of E	Business/Ir	
2121	- 10	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	MANIC	DO NOT us	se retired					METOL	OGY
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me	To Be	17. Father's Name (First, Middle, Last HENRY			STEIN	BERG		18. Mothe		(First, Middle,	Maiden Suma	me)	DUKATZ
	1 and 2 sho Health and tem 27 Is my other traumy		19a. Informant's Name/Relationship ROBERT RUDO / NE				-				OCEAN			
Baltimore,	0 0		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 €	Removal from State		Place of Dispo cemetery, crer	natory or o	ther plac			ate	20c. Location	-	
Itim	Pa Int:		4 □Donation 5 □ Other (Special Signature of Funeral Service Lice		ANS				CHAI s of Facility		/28/06			E, MD S., INC.
Ba	permit. Departr Importa		1 Buston H.	Kerinson	<i>}</i>									E, MD 21208
			23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final	one cause on each	line.	h. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. Due to (or a	sconseq	juence of):	7							
п	Examiner	-	Sequentially list conditions,	b. Due to (or a	s a conseq	uence of):								
	outed and ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с.	,									
8760,	cate be executed oblysician and the burial-transit	ai Exa	resulting in death) Last	Due to (or a	s a conseq	uence of):								
687	ficate physics the	edica		d										
O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent prepriant in the past 12 months? 1 ☐ Yes 2 ② No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 🗌 Feta	Ideath 3	Ectopic pro Other (sp.						ate of deliv onth	ery Day Year
0	ires that the designed by the	þ	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying c	ause give	en in Part I.			obacco use cor	tribute to t	the cause of death?
Records,	w requir been si should	ieted			-						24a. Was			
I Re	The ate h	Completed									autop perfor	sy med? 2. No	prior to co death? 1 Yes	opsy findings available ompletion of cause of
Vital	Physician: this certificant director, is) Be	25. Was case referred to medical examiner?	Hosoital:		150/0-1-1-1		Othe			(Check only of			
ō	Phy ratio	n: To	27. Manner of Death	28a. Date of In	jury	28b. Time of Injury		8c. Injury Work			ne 5 Resid 28d. Describe h			TY)
Division	Attending r death. sctor: After y the fune	catio	1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not l	on			М	1 🗆 `	Yes 2 1					
DİVİ	s after of all Directed in by	Certification:	4 Homicide determined	280. Place of I	etc. <i>(Specif</i>	ome, farm, str fy)	eet, factory	r, office			City or Tow	n, State)	ber or Hun	al Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical		hysician: To the bes miner: On the basis and manners	of examina	A			Caller Manager					
	Vithin To th	M	29b. Signature and title of certifier	26/	,		290	. License	number			29d. Date sign		
	7		· coar c	YOUR		- 00x \ CT	Data:)/5	387	2	/	May 2	5,	2006
l	0		30. Name and address of person who	completed cause of	death (Iten	п 23a) (Гуре,	erint)	5%	eek		211	36		
	Sta Regist		31. Date filed (Month, Day, Year)		trar's Signa	m 23a) (Type,	ule							

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Physician/ Medical Examiner 1. Decedent's Name (First, Middle,Last) Sue A. Zirkle 4a. Facility Name (if not institution, give street and number) Route # 272 @ Warburton Road Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 12. Date of Death Month Month Day May 25, 2006 4b. City, Town, or Location of Death North East Cecil Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Death Month Day May 25, 2006 4c. County of Cecil	3: Time of Death 1754 hrs
4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Route # 272 @ Warburton Road 4c. County of North East Cecil	
	Death
5, Social Security Number 6 Sex 7. Age (iii vis. last birtingly) ii onder 1 fear ii onder 24ms 6 Date of birtingly////// 17 Y	O. Birthaless (Ct.)
Director 190-44-0605 1 M 2 N F 53 Yrs Months Days Hours Min. Feb. 22, 1953	9 Birthplace (State or Foreign PA
Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location	10d Inside City Limits
The second secon	1 Yes 2 No
The work of the wo	t Country?
The state of the specific of t	American Indian, Black, etc.
3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify Specify or Dates:	white
15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busing most of working life. DO NOT use retired)	ness/Industry
Property of the property of th	rtation
Payroll Clerk Transpo	
To go proper the state of the s	State, Zip Code)
Floyd G. Zirkle, Jr. / husband 108 N.E. Isles; North East, MD 21901	
Floyd G. Zirkle, Jr. / husband 108 N.E. Isles; North East, MD 21901 20a Method of Disposition 20b Place of Disposition (Name of cemetery, crematory or other place) 20c Location - Company or other place)	City or Town, State
200 Place of Disposition (Name of Centerly) 1	ast, MD or loa
21. Signature of Fine ral Ary certificansee 22. Name and Address of Facility TOES 7 Ruck Towson Funeral Home Towson	, MD 21204
Physician 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.	Approximate Interval Between Onset and
Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Death
Sequentially list conditions.	
if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause c.	
if any, leading to immediate cause. Enter Underlying Cause Classes or i, ii, if a tilitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): UNPENDED AMENDED IF FEMALE 23b. Were decedent prograph in the	
d Liste pre case of the provided at a large provided at the pr	
99 y	elivery Day Year
Month Compared to the post 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (Specify) 7 1 Yes 2 No 9 Unknown 2 Unknown 2 Unknown 3 Ectopic pregnancy Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 2 The post 12 Th	Say Facility
	Ite to the cause of death?
Contributing to death out not resulting in the underlying cause given in Part 1 Yes 2 No 3	Probably 4 Unknown
The law requires The law requires The law requires The law requires The law requires Strong St	ere autopsy findings available or to completion of cause of
performed? de. 1 ✓ Yes 2 No 1 √	ath? Yes 2 No
The state of the s	
examiner? Nursing Home 5 Residence 6	
24a. Was an autopsy performed? 1	
System 5 2 Maccident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Town, State)	or Rural Route Number, City
Route # 272 @ Warburtor	Road, North East, Md
To the desk only (Check only one) 2 Medical Examiner: On the dasks of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner a desk of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner a death occurred at the time, date and place, and due to the cause(s) and manner a death occurred at the time, date and place, and due to the cause(s) and manner a death occurred at the time, date and place, and due to the cause(s) and manner a death occurred at the time, date and place, and due to the cause(s) and manner a death occurred at the time, date and place, and due to the cause(s) and manner a death occurred at the time, date and place, and due to the cause(s) and manner a death occurred at the time, date and place, and due to the cause(s) and manner a death occurred at the time, date and place, and due to the cause(s) and manner a death occurred at the time, date and place, and due to the cause(s) and the date and place are the date and place are the date and place are the date and place are the date and place are the date and place are the date and place are the date and place are the date and place are the date and place are the date and place are the date and place are the date and place are the date and place are the date and place are the date and place are the date and place are the date are the date and place are the date ar	
and manner stated 29c License number 29d. Date signed	(Month, Day, Year)
O.C.M.E. May 26, 200	6
30. Name and address of person which completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31 Date filed (Month, Day, Year) Registrar MAY 3 0 2006 Registrar's Signature	

		For State	State of	Maryland		artment of H		Mental Hy	giene ()	06	16861
		1. Decedent's Name (First, Middle	le, Last)			imodic or i	Journ	2. Date of De			3. Time of Death
Physic		Charles		- 7.1.	thof	F		May 13	, 2006	Year	5:00 P M
/Medi		4a. Facility Name (If not institution			CHOI.	4b. City, Town, or	Location of Deat		-	y of Death	J.00 P
Exami	iner						tte Hall		g+	. Mar	77 9
Europe		Charlotte Hall 5. Social Security Number		Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi		9. Birth	place (State or Foreign
Funeral Director		213-10-2200	1 ∑ M 2□F	87	Yrs.	Months Days	Hours Min.	June 4	1918	Mary	land
		Usual Residence of Decedent						100000		7	
yland		10a. State 10b. County		10c. City,	Town or Lo	ecation					10d. Inside City Limits
Mar Fed	ţo	MD Cal	vert			Huntin	gtown				1 ☐ Yes 2 🔀 No
r 28g	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntry?
38 o	D E	2725 Plum Poi	nt Road			20639			USA		
filed within 72 hours after death with the Maryland Hygiene. Ither then "neture!", or Items 23e or 28e-f show ont, Ite Marical Examirer must be notified at	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S.	. 13.	Was Decedent of Hi	spanic Origin? (S	pecify Yes or No		ce - Ameri	
after or Ite	T.	1 Never Married 2 Mar				_	Specify:	o riican, etc.,			etc.
rel', o	i by	3 ₩Widowed 4 Divorced	Year or Date	es: 1944–4	46	1∐ Yes 2√∏ No	эрвину.		Speci	" whi	ite
72 hi	Completed	15. Deceder	nt's Education est grade completed)		(Give	dent's Usual Occupa	turing most of wo	king	16b. Kind of E	Business/In	dustry
ithin 18.	du	Elementary/Secondary (0-12)	College (1-4	or 5+)		DO NOT use retired)				
ed w ygier yerth	Ö	7			ca:	rpenter					aryland
be fill tal H d oth	Be	17. Father's Name (First, Middle,	- 2 . 2				18. Mother's Nar	_	_		
should be nd Mental marked c	2	Charles Ambr		off			Mary	Eleano			
2 sh and is m		19a. Informant's Name/Relations				ng Address (Street a					
and ealth m 27		Linda M. Wills	on, daughte			Plum Poi	nt Rd.,				
of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from St	ate cen	netery, crer	sition (Name of matory or other plac		Date	20c. Location	- City or To	own, State
Pages ment of I ent: If it		4 ☐ Donation 5 ☐ Other (5		Gle	n Have	en Mem. P	ark 05-1	7–2006	Glen B	urnie	, MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other treumatic event, Ire Marical Examiner must be notified at any injury or other treumatic event, Ire Marical Examiner must be notified at once.	į	21. Signature of Funeral Service	Licensee			2. Name and Addres Rausch Fu		me. P.A	Owin	as. M	D 20736
		23a. Part 1. Enter the disease, o shock, or heart failure. Lis	r complications hat cau	ised the death.	-						Approximate Interval Between
Physician /Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	aPAR Due to (or	as a conseque	SON ence of):	(S W) 3	EASE	UITH I	ENFAT	IA	Onset and Death
cate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S c	as a conseque						- 1	
The law requires that the death certificat its has been signed by the attending phyage 2 should be detached for use as the	Physician/Medi	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ∏Fetal d nt at time of dea	leath 3	□Ectopic pregnancy □ Other (specify)				ate of delive	ery Day Year
quires that on signed I uld be det	þ	Part II. Other significant conditi	ions contributing to dea	th but not result	ting in the u	nderlying cause give	en in Part I.			ntribute to t 3 ☐ Prot	he cause of death?
	Completed							24a. Was auto perfo 1 Yes	s an 24b. psy prmed2 2LXNo	Were auto prior to co death? 1 \(\subseteq \text{Yes}	opsy findings available impletion of cause of
i cien: Th certificate rector, pag	Be	25. Was case referred to medica examiner?				2.	26. Place of Dea				
hysi this c	2	1 ☐ Yes 2 No	Hospital: 1 □ Inc		R/Outpatier		4 Xivursing F		idence 6 🗆 Ot		ý)
ing P	on:	27. Manner of D ath 1 Natural 5 □ Pendi	ng 28a. Date of (Month,	Day Year) 2	28b. Time o Injury	Work	(?	28d. Describe	how injury occu	rred	
or Attendi	Certification:	Accident invest 3 Suicide 6 Could 4 Homicide detern	nined 289. Place o	f Injury - At hom g, etc. (Specify)	ne, farm, str	M 1 1 1	Yes 2 □ No		(Street and Num wn, State)	ber or Rum	al Route Number,
	0			oct of my knowl		h occurred at the tim	ne date and place	, and due to the	cause(s) and m	anner as s	
ne Hospitel 124 hours a ne Funerel letely filled			ng Physician: To the b I Examiner: On the bas and manne	is of examinatio	on and/or in			rred at the time,		and due to	
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical Cer	(Check only 2 Medical	Examiner: On the bas and manne	is of examinatio	on and/or in		oinion, death occu	rred at the time,			o the cause(s)
To the Hospitel within 24 hours a To the Funerel I completely filled	edical	(Check only 2 Medical one)	Examiner: On the bas and manne	is of examination stated.		vestigation, in my of	oinion, death occu	76	date and place		o the cause(s)
To the Hospitel within 24 hours a To the Funeral IC completely filled	edical	(Check only 2 Medical one) 29b. Signature and title of certific	D Examiner: On the bas and manner er example to the completed cause	of death (Item 2	23a) (Type,	29c. License Print) e Centre,	pinion, death occurs in number	06	29d. Date sign	ed (Month,	o the cause(s)

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. U 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2006 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** omico Medical C eninbula Sbury If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 2 □ F 214-36-55 Yrs. 6 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or Items 23s or 28a-f show traumatic event, the Modical Externion must be notified at 1 Yes 2 No Completed by Funeral Director Omi CO 10e. Street and Number 10f. Zjo Code 10g. Citizen of Whal Country? 1801 0 6 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No BlACK Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DrIVER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JONES ည ma 19a. Informant's ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate - FEDERAL ONTEREY Date Method of Disposition 1 Burial 2 Cremation 3 Removal from State 06 hill CEMETER 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Service Licensee 13AbellA SALISBUM 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory artest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ONONar week disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c, If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown Š signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Wasan his certificate has b I director, page 2 sh prior to comple death? 1 Yes 2 autopsy virombocyb 2 A No 1 🗌 Yes penia fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 pnpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient ۵ 3 DOA this 27. Magner of D th 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After I Certification: 1 ANalural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Accident neral Director: / 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) determined after 4 Thomicide within 24 hours a To the Funeral C Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner slated. 29a. Certifier Medical completely 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signat

State

Registrar

teve

MAY 1

31. Date filed (Month, Day, Year)

201

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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MD

2006

			1 - For State Registrar	State of M		partment of ertificate of		nd Mental Hy	giene Reg. No.2 0 0 6	16863
	Physici	an	Decedent's Name (First, Middle, Last, Sarah Lorene					2. Date of Dea		3. Time of Death
i i	/Medio		4a. Facility Name (If not institution, give			4h City Town	n, or Location of D	May	22 2006 4c. County of Dear	3:30 A M
	Examili	ier	11702 Proenty				ganvill		Allegany	
	Funeral		5. Social Security Number 6. Sec		e (In yrs. last birthda		ar If Under 24		h 9. Birt	hplace (State or Foreign untry)
L	Director		159-12-5059 1L Usual Residence of Decedent	IM ZIXF	90 Yrs.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Dec 1	1915	PA"
	yland		10a. State 10b. County		10c. City, Town or	Location			-	10d. Inside City Limits
	Sa-fel	ctor	MD Allegan	Y	Corriga	anville				1 Yes 2 □ No
	within 72 hours after death with the Maryland ene. Then "naturel", or itame 23a or 28a-f ehow ha Madical Exeminar must be notified at	by Funeral Director	10e. Street and Number 11702 Proenty	Rd		10f. Zip Code	1524		10g. Citizen of What Co USA	untry?
	death	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of	of Hispanic Origin	? (Specify Yes or No- ruento Rican, etc.)	14. Race - Ame	
36	s after , or itu	y Fu	1 Never Married 2 Married	1 Yes 2 I	No	1 ☐ Yes 2 🎇 N		ueno Hican, etc.)		
8	Phour	ed b	3 Widowed 4 Divorced	Year or Dates:		edent's Usual Occ			16b. Kind of Business/	hite
215	thin 72 e. en "nu Medi	Completed	(Specify only highest grade	College (1-4or 5	(Giv	e kind of work dor DO NOT use reti	ne during most of ired)	working	100. Kind of Dusiness	moustry
2	led wi tygien her th	Con	8			memaker			Own Hom	e
anc	id be fi ental H ked of c ever	To Be	17. Father's Name (First, Middle, Last) William W. Hou	sel				Name (First, Middle, Redda (F	<i>Maiden Sumame)</i> Bittner) 1	Housel
Baltimore, Maryland 21215-0036	2 should and Miles mark	Ĭ	19a. Informant's Name/Relationship (Ty) ROSS E. Bittne	pe, Print)	19b. Mai	ling Address (Stre	et and Number o	r Rural Route Numbe	r. City or Town State 2	in Code)
e)	1 and Health em 27 Ither t		20a. Method of Disposition	I IIusi	20b. Place of Disp				ganville,	
E	Pages nent of I ant: If It		1 Burial 2 □ Cremation 3 □ R Under the state of the s	emoval from State	cemetery, cri	nn's Ce	olace)	y 25 06	20c. Location - City or Meyersda.	
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if tem 27 is marked other then "naturel", or itame 23a or 28a-f ehow eny injury or other traumatic event, the Madrial Examinar must be notified at once.		21. Signature of Funeral Service License	Land	Ju 1	22. Name and Add	dress of Facility	Hafer Fur	neral Serv	vice, PA
			23a. Parti. Enter the disease, or complished or heart failure. Listonly on	cations that cau ed					Vale, MD 2	Approximate
3	hysician		Immediate Cause (Final disease or condition		ortics.	4				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					1969/3
4	10.61	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to /r as	a consequence of):	it. Fa	1 10/6			2 days
al	cuted nd ransit	Examiner	man minated events							
8760,	cate be executed obysicien and the burial-transit	al Ex	resulting in death) Last	Due to (or as	a consequence of):					
/89	flicate p physics ts the	edical	d							
ROX	leath certifica attending pt I for use as t	M/W	230. Was decedent pregnant	3c. II yes, outcome		75		100	23d. Date of deli	very
	0 00 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown		□Ectopic pregnan □ Other (specify)			Month	Day Year
ري ت	requires that the	by Ph	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the	underlying cause g	given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
ecords,	w require been sig should b	ted						_ 1 🗆 Ye	as 20 No 3 Pro	bably 4 Unknown
ပ္တ	8 0 0 1 S T 20	Completed						24a. Was a autops	y prior to a	opsy findings available ompletion of cause of
	sician: The li certificate ha irector, page 3	ပ္ပို	25. Was case referred to medical						Yes 1 ☐ Yes	No
<u> </u>	≥ 0 0 l	To B	examiner?	ospital:	nt 2 ☐ ER/Outpatie	nt 3□ DOA O	26. Place of L Other: 4 \(\sum \) Nursin	Death <i>(Check only on</i> d Home 50€ Reside	e) ence 6 ⊡Other <i>(Spe</i> c	ful
	ding Ph h. After th funeral		27. Manner of Death ☐Metural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time o				ow injury occurred	•••
DIVISION	Attending ir death. ector: After by the fune	ertification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a Place of Inju			☐Yes 2☐No	20(1)		
2	spital or Atten ours after deat terel Director: filled in by the	Cert	4 ☐ Homicide determined	building, etc	rry - At home, farm, st :. (Specify)	reet, factory, office	9	City or Town	reet and Number or Rui n, State)	al Route Number,
	I o the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 2 Medical Examin	er: On the basis of and manner sta	examination and/or in	th occurred at the ovestigation, in my	time, date and pla opinion, death or	ace, and due to the ca courred at the time, da	ause(s) and manner as a	stated. o the cause(s)
1	vithii To th	×	29b. Signature and title of certifier		14/	29c. Licer	nse number	25	9d. Date signed (Month,	Day, Year)
	2				70	DOO	59479		05 24 0	6
	0		30. Name and address of person who con GEORGE HENNAW	. /	eath (Item 23a) (Type)	1 N	sh Rd s	Suites Co	in booking	MD 21502
R	Stat	~	31. Date filed (Month, Day, Year)		r's Signature	ell's	-11 1101 -	حرارات (ل	1100 CKIWIY	1 10 21302
	Registra	ir	MAY 3 0 2006	Con 100	10 100					

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6-03128		Please Type or Print in Black Indelible Ink	
amar Ronald B	Bell	State of Maryland / Department of Health and Mental Hygiene	
Division	/	Registrar Certificate of Death Reg. No. (U U)	158
Physici Medical Exam		Jamar Ronald Bel1 2 Date of Death Month Day Year May 9, 2006 1018	
Superior of the same		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
		4108 25th Avenue Temple Hills Prince George's	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (Str. 21/4_0/4_1531) Months Days Hours Min. Foreign Wash	ate or
J Director			DC
Ý.		Usual Residence of Decedent 10c. City, Town or Location 10d. Inside 10a. State 10b. County 10c. City, Town or Location 10d. Inside	e City Limits
, Maryland 28a-f show any d at nee.			s 2 No
ırylanı Sa-fsh atono	cto	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiers, or items 23a or 28a-fishe traumatic event, the Medic of Examiner must be notified at once	Director	10500 Catalina Place 20695 United States	
with t ns 23s		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	Black,
death or iter	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc	
after ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify. Specify. Black	
hours 'natu	eted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	
36 hin 72 than '	ble		
21215-0036 wild be filed within 72 hours al Mental Hygiene. marked other than "natural e event, the Medie "Examin	Compl	Twelve Two Student College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Marden Surname)	
215 be file ntal H rked e	Be	Kevin Flewellen Karen Bell	
221 hould I nd Mer is man	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
MD and 2 sho alth and im 27 is raumati		Karen Bell Berry 10500 Catalina Place, White Plains MD 20695 20a. Method of Disposition Date 20c Location - City of Town State 20b. Place of Disposition (Name of cemetery Date 20c Location - City of Town State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 permit. Health and Mental Hygien I mortant: Ultern 27 is marked other than injury or other traumatic event, the Medic al		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State	*
ti Pag tment rtant:		4 Donation 5 Other Specify: Harmony Memorial 2006 Landover Maryla	
Bal Bermi permi Depar Impo		21. Signature of Funeral Service Ucensee 22. Name and Address of Facility Robert G. Mason Funeral Ho	
Physician		23a. Part I. Enter the Isseas or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approxim	nate Interval
/Medical		failure. List only one cause of each line.	Onset and
Examiner		or condition resulting in death) Due to (or as a consequence of):	
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3	miner	if any, leading to immediate Due to (or as a consequence of):	
sit d	Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
OX 68760, cath certificate be executed attending physician and for use as the burial - transi		d.	
60, e be e ysicial burial	edic		
Box 68760, c death certificate be execut the attending physician and ed for use as the burial - tra	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
ox 6 ath cer attendi	Sicie	1 Ves 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)	
. Bc the dea y the s	Phy	D. 18 Off in 15 in 180	
P.O. es that th igned by	ক্র	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of 1 Yes 2 No 3 Probably 4 V	
ds, equire een sig	Completed	24a Was an 24b. Were autopsy finding	
COF lawr has b	헏	autopsy prior to completion or performed? death?	
Re: The iffcate		1 ✓ Yes 2 No 1 ✓ Yes 2	No
/ital sician is cert lirecto	o Be	examiner?	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stander death are Affect this certificate has been signed by led in by the funeral director, page 2 should be detach	 - 	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury accurred	
On cending sath or: A the fur	힐	Natural 5 Pending Find 5 (0/2006 Find 10.11 cm 1 Yes 2 No under	
ivisior or Attend after death Director:	iţi	Accident investigation 111d 3/ 3/ 2000 111d 10 111 dan	umber, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death within 24 hours after death "Jordf Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Certification:	4 Homicide determined (Specify) at home Temple Hills, M	
ne Hos 7 24 hv 7 Fun Tetely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.	
To th within Complete	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated	
,	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year	r)
		Therdure le Virg ruy O.C.M.E. May 10, 2006	
", "		30. Name and address of person who completed Suse of death (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	

State Registrar

31. Date filed (Month, Day, Year)

82. Registrar's Signature

			1 - For State Registrar	State of Maryla			f Health and of Death	Reg	0.00	16865
	Physici /Medic		1. Decedent's Name (First, Middle, Las EMILY CL	ARKE	Bon	VIE		2. Date of Death Month	Day Year 200	3. Time of Death 6 04:06 M
<i>)</i>	Examin	er	4a. Facility Name (If not institution, give SINAI HOSPITAL	OF BALTI		BA	n, or Location of Dea	5		IMORE
	Funeral Director		5. Social Security Number 6. Security Number 213-30-1130	7. Age (In yr	s. last birthday) Yrs.	If Under 1 Ye Months Da		. (Month, Day, Yo		thplace (State or Foreign ountry) ARYLAND
	h the Maryland rr 28a-f show	ctor	10a. State 10b. County MARYLAND CHAR		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes ZXINO
9500-6121	within 72 hours after death with the Maryland ene. Then "natural", or iteme 23e or 28e-f show he Mardical Experiment has been pulled at	Completed by Funeral Directo	10e. Street and Number 4225 SOUTHWIND: 11. Marital Status 1 Never Married 2 Marned WWidowed 4 Divorced 15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	12. Was Decedent Ever in Armed Forces? 1 Yes XXNo II Yes, Give Year or Dates:	16a. Deced	Vas Decedent de Yes, specify Company	0695 of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	o. Kind of Business	A ancan Indian, le, etc. IITE //ndustry
and z	be filed tal Hygi d other event, I	Be	11 17. Father's Name (First, Middle, Last) FRANK EDWIN CI	ADKE	POST	MASTE	18. Mother's Na	me (First, Middle, Mai	den Sumame)	ERNMENT
Mary	nd 2 should lith and Mer 27 is merker r traumatic	To	19a. Informant's Name/Relationship (7	ype, Print)	1,000		eet and Number or R	MAE HOPE		Zip Code)
Battimore,	permit. Pages 1 er Department of Hea Important: if item any injury or other ance.		20a. Method of Disposition 1 \(\mathbb{B}\) urial 2 \(\mathbb{C}\) remation 3 \(\mathbb{D}\) 4 \(\mathbb{D}\) Donation 5 \(\mathbb{D}\) Other (Specify) 21. Signature of Funeral Service Licenses	20b. Removal from State TRINIT	Y MEMO	RIAL (Name and Ad	GDNS . 5-		Location - City or	
00/00/	w requires that the death certificete be executed X Death of the attending physician and should be detached for use as the burial-transit at a large transit at a l	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ilications that caused the de ne cause on each line. A SPIRATION Due to (or as a consect of the	ath. Do not enter ON Paquence of): DUCT equence of): C AA	A PLAT	bying, such as cardia			Approximate Interval Between Onset and Death 3 HOURS WEELS MONTHS
O. DOX 0	the death certific y the attending p iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of preg 1 ∐Live birth 2 ∭Fe 4 ∭Pregnant at time of 9 ∭Unknown	tal death 3 ☐	Ectopic pregna Dther (specify)			23d. Date of del Month	ivery Day Year
cords, r	The law requires that the site hes been signed by the page 2 should be detached.	þ	Part II. Other significant conditions co	ntributing to death but not re	sulting in the un	derlying cause	given in Part I.	23e. Did tobace		the cause of death?
	8 8 8	Completed	1					24a. Was an autopsy performed	2/ prior to death?	topsy findings available completion of cause of
AIIB	siciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:			7th	ath (Check only one)		
VISION OF	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ation: To	1 Yes 2 No 27. Manner of D ath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	□ ER/Outpatient 28b. Time of Injury	28c. In	4 □ Nursing H njury at Vork? □ Yes 2 □ No	dome 5 ☐ Residence 28d. Describe how i		cufy)
	tel or Atters at Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, offic	се	281. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	the Hosp in 24 hou the Funer ipletely fill	Medical	one)	sicien: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death nation and/or inve	estigation, in m	y opinion, death occi	urred at the time, date	and place, and due	to the cause(s)
)	Con With	~	29b. Signature and title of certifier	m.D.			ES 0		Date signed (Mont)	
	10		30. Name and address of person who come MICHAEL G. Hous	END SINA	em 23a) (Type, P	rint)	BALTIMOR	20 M	V. BEZUEDE	TRE AUE
	Sta Registr		31. Date filed (Haveth 30a) 0 2006	32, Registrary Engr	naty	2				

DHMH 17 Rev 1/2001

	4	For State		f Maryland / De		nt of H	lealth a	and M		giene	b n	0.6	168	166
		Registrar 1. Decedent's Name (First, Middle,	Last)		Crimcai		Journ		2. Date of De	Reg. No.		00	3. Time of	Death
Physician	n								Month	Day O I	/	2006	5:58	a M
/Medica		Eugene Raymus	Bell		4h City	Tours	Logation	of Dooth	May			y of Death	3:30	
Examine	r	4a. Facility Name (If not institution,		mber)	1		Spri:					tgome	2 77	
		Holy Cross Hosp 5. Social Security Number	S. Sex	7. Age (In yrs. last birtho		r 1 Year	If Under		8. Date of Bi		PIOL		ace (State o	r Foreign
Funeral		579-96-5617	1(X)M 2□ F	34 Yr	Months		Hours	Min.	April	ay, Year)	972	Wach	ington	
Director	-	Usual Residence of Decedent				L			MPLII	13,1	712	Masii	11160011	., 20
land ow		10a. State 10b. County		10c. City, Town of	r Location							11	0d. Inside Cit	y Limits
Man,	Į	Maryland Monts	gomery	Silver	Sprin	g							1 ☑ Yes	2 🗌 No
r 28a	i ec	10e. Street and Number	<u> </u>			Code				10g. Cit	izen of	What Coun	try?	
3a o	Funeral Director	8210 Colonial 1	Lane		2	0910				Un	ite	d Sta	tes	
deati	Jer.	11, Marital Status	12. Was Dec	edent Ever in U.S. prces? 1989	13. Was Dece	dent of H	ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	D-		ce - Americ		
or Ite	2	1 Never Married 2 Marrie	1 XYes If Yes, Gi	2 □ No -	1 ☐ Yes		Specify:		riioaii, etc.)			ack, White,	HC.	
rel.	Š	3 Widowed 4 Divorced	Year or D	ates: 1992	1 🗆 1 63	2 63 140	Specify.				Speci	Bla	ck	
72 h	Сотріете	15. Decedent's (Specify only highest		16a. D	ecedent's Usu Give kind of wo fe. DO NOT u	al Occupa	ation during mos	t of worki	ing	16b. Ki	ind of E	Business/Inc	lustry	
ithin Jen Me		Elementary/Secondary (0-12)	College (1-40r5+)						_	1			
ygier th	5			5	tore M	anage			(F) . 14:14	1	'ood			
tal H d oth	Pe	17. Father's Name (First, Middle, L							First, Middle	, maiden	Suma	me)		
Men Marke Marke	0	William Lloyd							Bell					
12 sh and Is m		19a. Informant's Name/Relationsh							a <i>l R</i> ou <i>te Numb</i> lver Sp					110
l and lealth m 27 her t		Edna M. Bell /	Mother	O∠I 20b. Place of D	666.6		Lane	•	TVEL SP					10
Og = Its		20a. Method of Disposition 1 □ Burial 2 🏿 Cremation	3 □Removal from	State cemetery,	crematory or	other plac						- City or To		
tant:	-	`4 ☐ Donation 5 ☐ Other (Sp		Ft. Lin			- 1						Maryla	nd
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show eny injury or other traumatic event, Its Medical Examinar must be notified at once.		21. Signature of Funeral Sergice L	icensee	74	Simple	nd Addres Tril	ss of Facili oute	K Tune:	ral and	Cre	mat	ion C	enter	
00 5 9 0		vy s.	9						; Rockv		, M	aryla		
		23a. Part1. Enter the disease, or of shock, of eart failure. List of	nly she cause on	each line.	enter the mo	de of dyln	g, such as	cardiac o	or respiratory a	irrest,			Approximate Interval Bety Onset and D	ween
Physician		Immediate Cause (Final disease or condition	Seven	e Sepsis									Criodi aria b	
/Medical Examiner		resulting in death)		(or as a consequence of)	:									
	_	Sequentially list conditions,	b. Pneun											
sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	(or as a consequence of)			Comd							
and I-tran	хад	that initiated events resulting in death) Last	U	red Immune (or as a consequence of)		ency	Synd	rome						
building	cal			(0. 45 4 00/150440/100 01)										
a × a 1	edic		d									- 1		- 1
± 00 m		IF FEMALE:	23c If yes ou	tcome of pregnancy							024 D	ata af dalisa		
atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	pirth 2 Fetal death	3 Ectopic p		•					ate of deliver onth		'ear
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn		3 🗆 Other (s)	Decity)								
res that the designed by the a libe detached for the all the a		Part II. Other significant condition	s contributing to d	eath but not resulting in the	ne underlying	cause give	en in Part I		23e. Did 1	tobacco u	ise con	tribute to the	e cause of de	eath?
sign d be	g	End Stage Renal		-	, ,				10	Yes 21	X No	3 🗆 Proba	ably 4 □U	nknown
w require	Completed			-					24a. Was		246	Mora autor	findings a	
has be 2	E E								auto		240.		sy findings a apletion of ca	
									1 ☐ Yes	2X No			2 No	
certif	Re	25. Was case referred to medical examiner?	Hospital:			Oth Oth	05		(Check only					
this H	0	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date	Inpatient 2 ☐ ER/Outp		UA	4 L NU		me 5 Resi)	
ding P	lo lo	1 XNatural 5 ☐ Pending	(Mor	th, Day Year) Inju	iry M	28c. Injun Worl	k? Yes 2□				, 0000			
death death ctor: / the	Ca	3 ☐ Suicide 6 ☐ Could no	ot be 280 Black	of Injury - At home, farm					28f. Location (Street an	d Num	ber or Rural	Route Numb	2er.
I or Attendi after death. Director: A I in by the fu	ertification:	4 ☐ Homicide determin	build	ing, etc. (Specify)	, -11-5-1, 15-11-1	,,			City or To					
spite ours ours filled	S	29a, Certifier 1X Certifying	Physician: To the	e best of my knowledge, o	death occurred	at the tim	ne, date an	id place, a	and due to the	cause(s)	and m	anner as sta	ited.	
24 h	edical	(Check only 2 Medical E	xaminar: On the b	asis of examination and/oner stated.	or investigation	n, in my o	pinion, dea	th occurr	ed at the time,	date and	l place,	and due to	the cause(s)	
To the Hospitel or Attendit within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Me	29b. Signature and ittle of certifier	7.11.1.1		29	c. License	e number			29d. Dat	e signe	ed (Month, E	Day, Year)	
1-VA		▶ NWH	MYNX		ח	63579	9			5/1	2/2	006		
1-41	ŀ	30. Name and address of person w	no completed cau	se of death (Item 23a) (To		00013	,			J/ L	4; Z	000		
		Maria Tayag, M.				d: S:	ilver	Spr	ing. MD	209	10			
State	e	31. Date filed (Month, Day, Year)	32.	00 Forest G1 Registrar's Signature	Annale)	, D.		JPI.		20)				
Registra		MAY 15	2006	MUST AS 1										

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 7:00A M May 10 2006 Margaret Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. March 8 1 Anne Arundel Copeland St. 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** 1 □ M 20 F 1928 Maryland Director 214-26-3500 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 288-f show other traumatic event, the Medical Examinar must be notified at Maryland Anne Arundel 1 XYes 2 No Annapolis Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1917 E Copeland St. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status within 72 hours after Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes XXNo **Black** ξ XXWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker Private Family 10th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked othe eny injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Johnson Sr. Phillippi Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1917 E Copeland St. Annapolis, Md. 21401 Sylvia Roberts(Daughter) 20b. Place of Disposition (Name of Homelary Cremater or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Memorial Gardens 5-17-06 Annapolis, Md. Win Reese of Earling Mortuary, P.A. 21. Signature of Funeral Service Licensee Lang 13. Resai M00483 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of sying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the attending IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for Month Day Year 4□Pregnant at time of death 5 Other (specify) Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II Division of Vital Records, ۵ After this certificate has been signed funeral director, page 2 should be 2**√** No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural

2 Accident Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how intury occurred Certification: To the Hospons after death.

To the Funerel Director: Aft 5 Pending 1 ☐Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and or exestigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. Medical revestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only onel 29c. License number 29d. Date signed (Month.jDey, Year) 29b. Signature and titte/of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature 31. Date filed (Mo. State

Registrar

			1 - State Registrar	State of Maryland		irtment of H tificate of I			iene 20	06 16868
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	th_	Year 03. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)	14		Location of Death	may	4c. County	
	Funeral Director		5. Social Security Number 6. Sex	MCQ/LOC CA4 7. Age (In yrs. las 85	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 4-26-1	Year)	9. Birthplace (State or Foreign Country) DAGSBORO DE
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits
	Ba-f et	Director	DELAWARE SUSSEX	DAG	SBORO					1 ¥ Yes 2 □ No
	with the		10e. Street and Number 33150 MAIN STREET			10f. Zip Code 19939			0g. Citizen of W	hat Country?
980	n 72 hours after deeth with the Maryland "natural", or Itams 23s or 28s-f ehow edical Exarch at most be notified at	by Funeral	-	2. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If	Vas Decedent of Hi	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No-		- American Indian, , White, etc.
21215-0036	d within 72 hou giene. Ir than "naturi Ire Medical E	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give I life. E	OO NOT use retired	during most of work	ing	16b. Kind of Bus	siness/Industry
d 21	Hyg Hyg the		17. Father's Name (First, Middle, Last)		HOMEM	AKER	18. Mother's Nam	e (First, Middle, M	NONE Maiden Sumame))
Maryland	0 2 2 0	To Be	WILSON O. MC CABE				OLA TIM	MONS		
Man	d 2 shi th and 7 is m traum		19a. Informant's Name/Relationship (Type				and Number or Run		28 6	State, Zip Code)
	Heg Heg		WILLIAM B. CHANDLE	20b. Plac	e of Dispos	Sition (Name of patory or other place			. 9939 20c. Location - C	City or Town, State
Baltimore,	Pe ant:		1 X Burial 2 Stremation 3 Re 4 Donation 5 Other (Specify)	noval from State	NCE GE	CORGE'S	5-18	3-2006	DAGSBORG), DELAWARE
Bal	permit. Per Depertmen Important: any injury once.		21. Si mature of Fundant Fryice Cens	n		Name and Addres LSON_FUNI ATCHER S	ss of Facility ERAL SERV FRANK	ISES: LI	D. 1994	5
)	Physician /Medical		23a. Karl. Enter the disease, or complic shock, or heart follure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre		Approximate Interval Between Onset and Death
1	Examiner		ſ	Due to (or as a consequer	nce of):	Ascro	disense			Sycan
	ed isit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen						· ·
68760,	icate be executed physicien end s the burial-transit	al Examiner	that initiated events resulting in death) Last	Due to (or as a consequen	nce of);					
	S t	Medical	IF FEMALE:							
P.O. Box	The law requires thet the death certificate hes been signed by the ettending bage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery h Day Year
	w requires thet been signed k should be det:	ρ	Part II. Other significant conditions control	ibuting to death but not resulti	ng in the un	derlying cause give	en in Part I.			oute to the cause of death? B Probably 4 Honknown
of Vital Records,		Completed						24a. Was ar autops perform 1 Yes 2	pri ned2/ de	ere autopsy findings available for to completion of cause of ath? Yes 2 No
Vit	Physician: this certific	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 popatient 2 EF	VOutpatient	3□ DOA Othe	26. Place of Deat			(Specify)
Division of	D 0 0	Certification; T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation		Bb. Time of Injury	28c. Injury Work	yat k? Yes 2 □ No	28d. Describe ho		
DIV	al or Att s efter d if Diract id in by	ertifi	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (Str City or Town		r or Rural Route Number,
	To the Hospital or Attandin, within 24 hours effer death. To the Funeral Diractor: Att completely lilled in by the fun	Medical C	29a. Certifier (Check only one) 1 ✓ Certifying Physic (Check only one)	cian: To the best of my knowle r: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time estigation, in my op	ne, date and place, pinion, death occurr	and due to the ca	use(s) and maniate and place, an	ner as stated. Indicate the description of the cause (s)
•	To the within 2 To the complet	Ž	29b. Signature and title of certifier	0 - 40 - 10	(12)	29c. License		25		(Month, Day, Year)
			30. Name and address of person who com	DR USHA N			1339		19 ay 14	TE 2006
PN	10									
	Sta Registr		14 15 - 5 - DIVISION 31. Date filed (Month, Day, Year) MAY 1 6 20	32. Registrar's Signatur	* A	book				

Y. CHANDLY 233.56-3847

EVA

		1	For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F ertificate of			ene 006	16869
19t.	Physicia	an	1. Decedent's Name <i>(First, Middle, La</i> Trinidad		Chicas			2. Date of Death Month May 1	Day Year	3. Time of Death 1928 M
	/Medic Examin	er	4a. Facility Name (If not institution, given Montgomery Ge	eneral Ho	ospital	Olne			4c. County of Dear	mery
	Funeral Director		5. Good	Sex 7. Ag 1 □ M 2 ½ F	ge (In yrs. last birthday 82 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, 8/22/1	Year) Co	hplace (State or Foreign buntry) Salvador
	72 hours after death with the Maryland natural; or Items 23a or 28a-f show iteal Exaction must be nutified at		10a. State 10b. County MD Montg	omery	10c. City, Town or L Rockvil					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	vith the	Direc	10e. Street and Number	n Arranua		10f. Zip Code	F 3	10	og. Citizen of What Co	ountry?
	r death v	Funeral Director	13305 Magella:	12. Was Decedent Armed Forces	?	208 Was Decedent of H If Yes, specify Cub		Specify Yes or No- to Rican, etc.)	USA 14. Race - Ame Black, Whit	
9000	nours afte ural', or II	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:		1 Yes 2□ No El Sal	vador			White
21215-0036	be filed within 72 hours after death with the Marylan Hygiene. I shall have natural; or items 23a or 28a-f show svent, it a Marified at svent, it a Marified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		16a. Dece (Giv. ife.	edent's Usual Occup e kind of work done DO NOT use retire Seamstr		rking	Clothi	•
b	be filed tal Hygie d other svent,	Be	17. Father's Name (First, Middle, Las unknown Corne			DCamser_	18. Mother's Na	me (First, Middle, M	fa <i>iden Sum</i> ame)	19
Maryland	thould be id Mental marked o matic sve	2	19a. Informant's Name/Relationship		19b. Ma il	ling Address (Street		efina Ch	City or Town, State, .	Zip Code)
	t. Pages 1 and 2 should b rment of Health and Menig rant: If tem 27 is marked nyryge giher trsumatics	-	Sonia Zapata/0 20a. Method of Disposition 1 Burial 2 \(\mathbb{D}\) Cremation 3 i	Great-nei	ice 133	05 Mage	llan Av	enue Roc	ckville, N	rd 20853
Baltimore,	ermit. Page Separtment of Important: If Iny injuryer	ì	4 Donation Cher (Spec	ity) []	Chesar	peake Cr			Beltsvil	
Ba	Per Per Per Per Per Per Per Per Per Per		23a. Part1. Enter the disease, or cor	ull	od the death. De not en	PHILIP 1 9241 Co.	D.RINAL lumbia	DI FUNER Blvd.Sil	RAL SERVI	CE, P.A. ng, Md20910
8	Physician		shock, or heart failure. List onh Immediate Cause (Final disease or condition resulting in death)	y one cause on each l	owel I	nfarc-	Hon			Interval Between Onset and Death
*	/Medical Examiner			b. A	s a consequeñce of):	levosi:	S			
	be executed sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):					
8760,	ate be exi hysicien (the burial	Cal	Todaking in additi) sale	d	s a consequence of):					
.O. Box 6	The law requires that the death certificate be executed are has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 DENO 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Dale of de Month	livery Day Year
ds, P.	uires that t signed by	þ	Part II. Dther significant conditions	contributing to death	but not resulting in the	underlying cause gr	ven in Part I.	23e. Did tob	s 2 2 40 3 P	o the cause of death?
Records,	The law requisete has been page 2 should	Completed						24a. Was ar autops penform	prior to death?	ulopsy findings available completion of cause of
Vital		Be C	25. Was case referred to medical examiner?					1 Yes 2 ath (Check only one		*2LNG0
of	ding Phys h. After this funeral di	P	27. Manner of Death 1 Shatural 5 Pending	Hospital: 1 Impat 28a. Dale of Inj (Month, Da	ury 28b, Time	of 28c. Inju			nce 6 Other (Spe w injury occurred	cify)
Division	or Attention deat lector:	Certification:	2 Accident Investigation 3 Suicide 6 Could not determine	be 28e. Place of Ir	njury - At home, farm, s etc. (Specify)			28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	Medical C			t of my knowledge, dea of examination and/or i					
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licen:	se number	25	9d. Datel signed (Mont	h, Day, Year)
				1 A A	117	1	100 DIC	1	6/17/10	-
	1		30. Name and address of person who	o completed cause of	death (Item 23a) (Type	DO a, Print)	06319 Millia	6	5/12/0	1/h 10000

			1 - State Registrar	State	of Maryla	and / Depa <i>Cei</i>	artmen rtificate				_	giene Reg. No	000	16	16870
		8	Decedent's Name (First, Middle, Las	t)							2. Date of De			/ n n r	3. Time of Death
=	Physicia /Medic	_	Edith Gertrude	Cranf	ord						May	14	20	006	12:30P M
	Examin		4a. Facility Name (If not institution, give	street and no	ımber)				Location	of Death			. County o		
		6 A	3400 Lancer Court 5. Social Security Number 6. Se		7 Ago (la vi	rs. last birthday)	Dunk If Under		If Under	24 Hrs.	8. Date of Bir		Calve		lace (State or Foreign
	Funeral Director			Эм 2 Д F	79	Yrs.	Months	Days	Hours	Min.	April Da	iy. _{Year} 9 19	27 V	Coun	ington, DC
	D		Usual Residence of Decedent												
	anylan show	_	10a. State 10b. County		10c.	City, Town or Lo	ocation							1	0d. fnside City Limits 1 ☐ Yes 2 ☑ No
	Ba-1 of	Director	MD Calvert 10e. Street and Number		D	unkirk	10f. Zip	Codo	_			10a Ci	tizen of Wi	at Cour	
	with t	Dir	3400 Lancer Court					754					ed St		•
	ne 23	Funerai	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Deced	lent of His	spanic Or	igin? (Spe	acify Yes or No		14. Race	Amend	an Indian,
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. and Mental Hygiene. anarked other then, "natural," or tieme 23s or 28s-f show semmatic event, the Madical Exameter interior collins as	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 反 Divorced	Amed F 1 Yes fl Yes, G Year or l	2 € No ive		ff Yes, spec 1 ☐ Yes		n, Mexicai Specify:		Rican, etc.)		Specify.	White, Thite	
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2	lled w tygier her th		17. Father's Name (First, Middle, Last)			Home	maker		18 Moth	er's Name	(First, Middle		Home		
anc	d be findal Hed of	Be	Ernest R. Humphrey	. Tr.					Haze.			, maiosi	Jumanie	,	
2	should and Men marke umatic	ဥ	19a. Informant's Name/Relationship (7	·		19b. Maili	ng Address				Il Route Numb	er, City	or Town, S	tate, Zip	Code)
	and 2: ealth a n 27 io		George R. Cranford	l, Jr.,	Son	3400	Lance	r Co	urt,	Dunk	irk, M	D 20	754		
ore,	of He of He rothe	3	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from		o. Place of Dispo cemetery, crea	osition (Nan matory or o	ne of ther place	9)		Date	20c. L	ocation - C	ity or To	wn, State
Ĕ	Pages ment of lant: If it		4 Donation 5 Other (Specify		Me	tropoli			COLY		9-06	Alex	andri	.a, '	VA
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic so <u>pnca</u> .	0	21-Signature of Funeral Service Liceo	all			^{2. Name} an ausch				, P.A.	Owi	ngs,	MD :	20736
	· (a)		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that	caused the de	eath. Do not en	ter the mod	e of dying	g, such as	cardiac o	or respiratory a	rrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Car	diac	Arrhyt	hmia								20 Mins
	/Medical Examiner		resulting in death)		(or as a cons	sequence of): Obstru	ctiv	e 101	ılmo	nary	Dise	ase		-	1 Year
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	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C											
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8760,	cate be executed bhysiclan and the burial-transit	dical	•	d									·····		
9	ding p	0	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pre	gnancy						11	23d. Date	of delive	ary.
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/M	n the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		birth 2∏F gnant at time o nown		⊒Ectopic pr ⊒ Other (sp						Mont		Day Year
<u>α</u>	that thed by	Ph	Part II. Other significant conditions of	ontributing to	death but not i	resulting in the u	inderlying c	ause give	n in Part	l.	23e. Did	obacco	use contrib	ute to th	ne cause of death?
ds,	uires tha signed ild be dei										10	Yes 2	□No 3	X Prob	ably 4 Unknown
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Re	The la	шо						1-11-11-11-11-11-11-11-11-11-11-11-11-1			auto perfe	psy ormed? 2₩ No	de	or to cor ath?] Yes	npletion of cause of
ita	ian: rrtifica ctor, p	Be C	25. Was case referred to medical examiner?						26. Place	e of Death	(Check only		1		
× ×	Physician: The lav this certificate has al director, page 2	2	1 ☐ Yes 2√∑ No			ER/Outpatie			4 🗆 141		me 51 Res				v)
nc C	ding P	ion	27. Manner of Death 1 X Natural 5 ☐ Pending		e of Injury nth, Day Year,	28b. Time o Injury	M 2	8c. Injury Work	rat ⊲? Yes 2. □		28d. Describe	how infu	iry occurre	1	
Division of Vital Records,	Attending Physician: r death. ector: After this certification of the funeral director, is	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Plac	e of Injury - A	t home, farm, st			163 2	-				or Rura	l Route Number,
<u>S</u>	ital or / rs after al Dire	Certification:	4 Homicide	buif	ding, etc. (Spe	ecify)					City or To	wn, State	θ)		
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Medicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exan	iner: On the											
	To the To the Comp	ž	29b. Signature and title of certifier	Do	0	\circ		. License					ate signed		-
)) 00		~	V	D	345	∠5			мау	16,	20	υb
	5		30. Name and address of person who												
	Sta	ato.	S.J. Rao, MD, 31. Date filed (Month, Day, Year) MAY 1	4000	Mitche Registr ø s Sie	ellvil gnature	Le Ro	1_#2	20,	Bow	ie, MI	20	716		
	Regist		MAY 1	6 2006	Henry	in the	Spa	ويملي							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#1, per/lb, 350,6/14/00 II

		1 _ State	State of Marylan		artment of H			ene No2 0 0 6	16871
10.00		Registrar 1. Decedent's Name (First, Middle, Last)	Doris Murtle Dor		timoato or	Douth	2. Date of Death		3. Time of Death
Physicia /Medic		Doris Myrtl	e Donaghue	08.100			May 23,	2006 Year	6:00 PM M
Examin		4a. Facility Name (If not institution, give st. Homewood at Crum1			4b. City, Town, o	r Location of Deat	h	4c. County of Dea Frederic	
Funeral	-	Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		ear) 9. Bir	thplace (State or Foreign
Director		155-18-4/2/	M 2 🖾 F 81	Yrs.	World S Days	110010	Jan. 7,	1925 Mar	yland
and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
Maryl feho	ļo	Maryland Frederick	Fred	erick					1 ☐ Yes 2 No
r 28a	Director	10e. Street and Number	Treat	LILL	10f. Zip Code		10g	. Citizen of What Co	ountry?
th with 23a o		7401 Willow Road			21702		us	A	
ges 1 and 2 should be filed within 72 hours after deeth with the Maryland to the Hand and Mentall Hygiene. In chealth and Mentall Hygiene. In chealth and Mentall Hygiene. In cother treumatic avent, the Medical Examinar must be notilised at	Funeral		2. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	fispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 □Yes 2 🕅 No If Yes, Give		1 ☐ Yes 2 📉 No	Specify:		Specify: Whi	
hour fure!		15. Decedent's Educa	Year or Dates:	16a. Dece	dent's Usual Occur	pation	16	b. Kind of Business	
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d with giene	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	Eleme	ntary Scl	nool Tead	cher Pu	blic Scho	ol System
al Hyg	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Ma	iden Sumame)	
Menta Menta rked	To E	Lewis J. Gorsuch					relia Zie	~	
2 she and and tem.		19a. Informant's Name/Relationship (Type	e, Print)				ural Route Number, C	•	Zip Code)
and land lealth ma 27		Lewis Donoghue, son			Glendale	e Drive,	Hagerstow Date 20	n, MD 21 c. Location - City or	742
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mit. Pages partment of portant: If if y injury or o		4 □Donation 5 □ Other (Specify) 21. Signature of fluneral Service □Consec			g Cremat				, Maryland
Datitinote, We permit. Pages 1 and 2 Department of Health a Important: If Item 27 it eny Injury or other tre once.		Lum n De	M009	399	Keeney ar	d Basfor	d PA Funer t., Freder	ral Home	21701
. T\$ ₀ ≠ 400	1	23a, Part1. Enter the disease, or complic	ayons that caused the death						Approximate
Physician		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	100.	. Ho	+ 0:	cense.		Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):	1/a	120	sense		4591)
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n certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna					23d. Date of de	livery
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The cete		Breast (1h(9)				performe 1 Tes 2		2 □ No
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ording th: Afte	tlor	2 Accident S Pending investigation	(Month, Day Year)	Injury		rk?]Yes 2∐No			
Or Attending after death. Director: After lin by the fune	flog	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, sti	reet, lactory, office		281. Location (Stre- City or Town,	et and Number or R	ural Route Number,
ed in grand of G	Certification:	4 El Holliodo	building, etc. (Specif)	·/			0.ty 3, 7.5mm,		
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical		cian: To the best of my kno er: On the basis of examina and manner stated.						
To thi Mithin To the	Me	29b. Signalure and title ol certifier	/// -		29c. Licen:	se number	290	. Date signed (Mont	th, Day, Year)
		1 RALIN	1 line 1	1/	D1642	8	N	May 24, 20	006
12		30. Name and address ol/person who con							
12		Casper E. Cline, I	II, MD, 300 W	est Ni	nth Stre	et, Fred	erick, Mar	yland 21	.701
Sta		Casper E. Cline, 1. 31. Date filed (Month, Day, Year) MAY 3 0 2006	32. Registrar's Stana	ture Cont					

	1 - For State Registrar	State of Ma	•	artment of Health and I rtificate of Death		ene g. No.2006 168	72
Physician /Medical	LIBITE A HOTMAN	it)			2. Date of Death Month May	13 2006 0642	
Examiner	4a. Facility Name (If not institution, give	.1.1	Pertel	4b. City, Town, or Location of Death	,	4c. County of Death	
Funeral	5. Social Security Number 6. S	7.70	(In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birthplace (State or Fo	-
Director	185-28-9490 Usual Residence of Decedent		67 Yrs.		Aug. 16, 1	938 Pennsylvania	
aryland	10a. State 10b. County		10c. City, Town or Lo			10d. Inside City L	
288-1 288-1	Delaware Sussex		Millvi	11e	10	t ☐ Yes 2)	TNO
\$ (Z \(\frac{1}{2} \) \(\frac{1}{2} \)	5402 Pettinaro Di	ive		19970		USA	
2 2 8 8 8	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	
		1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No Specify:		Specify: White	
21215-00 ed within 72 hor vgiene. Per then "nature it, the Medical Et, the Medical Et.	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king	6b. Kind of Business/Industry	
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Maryland : Maryland : d 2 should be file. th and Mental Hy. th is marked other traumatic event.	James Gillespie	S D1	10: 14:33	Mary Y			
	19a. Informant's Name/Relationship (7) Timothy A. Dorman	•		ng Address (Street and Number or Ru. 3 Wilgus Cemetery			
Series Series	20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 🔯	Removal from State		The state of the s		Oc. Location - City or Town, State	
Baltimore permit Pages 1s Department of He Important: If item	4 Donation Other (Specify	20		er & Paul Cem 5/18	/2006 S _I	oringfield, PA	
Balt Bernit Depart Impo	21. Signature of Fur eral Service (Ic.)	30ll	200 Ze	? Name and Address of Facility ller Funeral Home 06 Main Street, E	, P.O. Bo	ox 207 Market MD 21631	
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Box 68 sath certificat attending phy for use as th	IF FEMALE:) Min	_		
IS, P.O. Box 687 res thet the death certificate igned by the attending phys be detached for use as the by Physician/Medic.	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1☐Live birth 2 4☐Pregnant at tii	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
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II Record The law requir cate hes been s page 2 should					-	2 No 3 Probably 4 Onkn	
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Of V Physic this or ral dire	1 Yes 2 No	Hospital: Inpatient 28a. Date of Injury				ce 6 □Other (Specify)	
ion nding ath. r: After e fune	1∕2 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	injury occurred	
Division of Vital Records, tel or attending Physician: The law requires the stert death. el Director: After this certificate hes been signed in by the funeral director, page 2 should be Certification: To Be Completed by	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)	
		reicien: To the best of	my knowledge, death	n occurred at the time, date and place,	and due to the co-		
he Hosp in 24 hou he Funer pletely fii	(Check only 2 Medical Examone)	iner: On the basis of e and manner state	xamination and/or inv	vestigation, in my opinion, death occur	red at the time, dat	e and place, and due to the cause(s)	
To the within To the comp	29b. Signature and title of certifier	/		29c. License number	290	d. Date signed (Month, Day, Year)	
	Jucky 30 Norman Line	omoloted sauce of it	oth (Itom 202) (T	D31887		5/13/06	
	30. Name and address of person who of WALTER P. LISCHIC	kmb 10	DO F. CARR	OLL St. SALISHI	in mo	, 21801	
State	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1 4	7		
Registrar		- The	Me So A				

		1 - For State Registra MEND#26perMC	5/15/06,BMW,N	•	•	artment of H			Reg. N	2006	16873
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Examir Funeral Director	ier	3122 Gracefiel	d Road, #1	.07	last birthday) Yrs.		Spring	J	Birth Day, Yea	Montg	
P .	tor	Usual Residence of Decedent 10a. State 10b. County New		10c. Cit	y, Town or Lo			puly), I:		10d. Inside City Limits
death with the Maryland me 23a or 28a-f ehow rnust be natified at	Funeral Director	10e. Street and Number 1082A Long Beac	h Blvd.		OI CH B	10f. Zip Code	008		10g. (Citizen of What Cou	ntry?
be filed within 72 hours after death with the Marylar tall Hygiene. and ther then "naturel", or iteme 23s or 28s-1 show overt, the Madical Examinational transitied at	þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces	?] No		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No		? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Ameri Black, White Specify: Wh	, etc.
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s 1 and I Health Item 27 other tr		19a. Informant's Name/Relationship Rita M. Donahue, 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	/ Wife □Removal from State	3	3122 Place of Dispo		ld Road		Silv 20c.	y or Town, State, Zi ver Sprin Location - City or T nmit, New	g, MD 20904 own, State
permit. Pages Department of Important: If eny injury or 2002.		21. Signifure of Funeral Service Lie	censee		F1	Name and Address 30 Univer	sity Bl	ıs Funera	al Ho	ome Inc. er Spring	, MD 20901
ilicate be executed /Medical Examiner Medical Exa	dicai Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a	s a consequence of the consequen	uence of): Stive juence ol):	L		gitati ailure brilla		^	Interval Between Onset and Death
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The law ate has b	Compl	OF Was seen released to modical						pe 1 🗆 Yes	topsy rformed? 201	prior to co	opsy lindings available ompletion of cause of
Phys or this aral di	on: To Be	25. Was case relerred to medical examiner? 1	Hospital: 1 Inpat		ER/Outpatier 28b. Time of Injury	28c. Injun Wor	er: 4 □ Nursir y at k?		Sidence	Second Re full occurred	gidence
or Attendate deatl	Certificati	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of Ir	njury - At h	ome, farm, str fy)	M 1 1	Yes 2 □ No		(Street Fown, Sta	and Number or Run ate)	al Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	Medical ((Check only 2 Medical Ex	Physician: To the best taminer: On the basis and manner s	of examina	owledge, deatl ation and/or in	vestigation, in my o	pinion, death o	lace, and due to the courred at the time	e, date a	and place, and due t	o the cause(s)
To the within to the complete	2		Puthum				9524		M	Date signed (Month,	2006
St. Regist	ate	30. Name and address of person with LOVEEN J. Polymers 31. Date liled (Month, Day, Year)	THUMAN 32. Togis	1 A, trar's Signa	3110 ature	GRACE	FIELD	ROAD,S	ILVE	ERSPRIN	5, MD 20 90L
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			For State Registrar	State of Mai	yland	-	artment o			nd M	ental Hy	/giene	2 U L)6	168	74
	5		Decedent's Name (First, Middle, Last)							2. Date of D			V	3. Time of D	eath
2	Physici		Charles	Frederio	¬k	D	obson				Month May	13.	, 2006	Year	10:55	\mathbf{p}^{M}
1	/Medic Examin	200	4a. Facility Name (If not institution, give				4b. City, Tow	vn, or Lo	ocation of	Death	1 1		County			
		-3A -3"	5963 Solomons Is: 5. Social Security Number 6. Se		(In yrs. la	st birthday)	If Under 1 Y	ear I	Lanc	4 Hrs.	8. Date of B	irth	Anne	9. Birthp	ace (State or I	Foreign
養	Funeral Director		213-32-6409	д м 2□ F	70	Yrs.	Months Da	ays	Hours	Min.	Oct 2	a <i>y, Year)</i> 0 . 19	935	Mary	land	
			Usual Residence of Decedent													
	rylan how	_	10a. State 10b. County		10c. City,	Town or Lo	cation							1	0d, Inside City	
	e Ma	cto	MD Anne Ari	undel			Trac	y's_	Land	ling					1 🗆 Yes 2	XINO
	ith th	Director	10e. Street and Number				10f. Zip Co					10g. Cit	izen of W		try?	
	ath w		5963 Solomons Is				1	0779					USZ			
	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28e-f show the Medical Exercinat must be notified at	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		i. 13. Y	Was Decedent f Yes, specify (of Hisp Cuban,	Mexican,	in? (Spec Puerto F	cify Yes or N Rican, etc.)	0-		- Amend c, White,	an Indian, etc.	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1)))	50	1 □ Yes 2 🔀	No .	Specify:				Specify:	whi	to.	
21215-0036	hour		15. Decedent's Edi		200-t	16a. Deced	dent's Usual O	ccupatio	on		-	16b. K	ind of Bus			
15	in 72 n "ne dection	Completed	(Specify only highest grad	le completed)		(Give	kind of work di DO NOT use re	one dur	ring most	of workin	g				,	
212	1 with	Eo	Elementary/Secondary (0-12)	College (1-4or 5+	'	const	ructio	n sı	uperv	/isor	2	CC	onstr	ructi	.on	
	I Hygie other	Be C	17. Father's Name (First, Middle, Last)					18	8. Mother	's Name	(First, Middle	e, Maiden	Sumame	9)		
<u> a</u>	Aental Aental rked c	To E	Thomas Frederic	ck Dobsoi	า			F	Berti	.e	Jeann	ette	Wh	nitti	ngton	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Haath and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23s or 28s-f show other traumatic event, I're Medical Exert har must be notified at	1	19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailir	ng Address (St	reet and	d Number	or Rural	Route Numi	ber, City o	or Town, S	State, Zip	Code)	
	and 2 ealth a n 27 lu		Lorraine Dobson, v	wife					Is. F	Rd.,	Tracy				D 2077	9
ore	of He of He fiten r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	20b. Pla	ace of Dispo metery, crer	sition (Name of natory or other	of place)		Di	ate	20c. Lo	ocation - (City or To	wn, State	
Ĕ	Pages nent of I ant: If its ury or o		4 Donation 5 Other (Specify,		St	. Jame	es Ceme	tery	у С)5–18	3–2006	Tra	acy's	Lar	ding, 1	MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licens	Gron			Rausch				, P.A	., Ov	vings	s, MI	2073	6
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ti ne cause on each line	ne death.	Do not ent	er the mode of	dying,	such as c	ardiac or	respiratory	arrest,			Approximate Interval Between	en .
	Physician		Immediate Cause (Final disease or condition	Don	en)	tiA	. H	121	hei	men	15	Tre	2 · E_		Onset and De	ath
*	/Medical		resulting in death)	Due to (or as a	conseque	ence of):		-			r's E	71				
	Examiner		Sequentially list conditions,	b. Kes	PIX	ata	14	<u>D</u>	ece	in	ers	Atio	000			
D.C.	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	gonseque	ence of):	J			V						
	eecut and I-tran	хап	that initiated events resulting in death) Last	cDue to (or as a	conseque	ence of):										
8760,	cate be executed physician and the burial-transit	alE			,	,										
687	icate phys s the	gle		d												
Box (seath certifica attending pt for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of									23d. Date	of delive	rv	
	that the death cer ed by the attendin detached for use	clar	in the past 12 months?	1□Live birth 2 4□Pregnant at ti]Ectopic pregn] Other (s <i>pecif</i>						Mon	th	Ďay Ye	ar
o.	t the d	hys	9 Unknown	9□ Unknown							,					
s, D	8 S 8	by P	Part II. Other significent conditions co	ntributing to death but	not resul	ting in the u	nderlying cause	e given	in Part I.						e cause of dea	
Vital Record	w requir been si should	Completed								-	1	Yes 2	No	3 🗌 Prob	ably 4 □Unl	known
ပ္ပို	e law r has be je 2 sh	ple									24a. Wa	s an opsy	24b. W	ere auto	osy findings av	railable use of
<u>т</u>		No.									perf 1 ☐ Yes	ormed?	de	eath? □ Yes		
ita	ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?					2	26. Place	of Death	(Check only	one)				
× ×	Attending Physician: The la ir death. ector: Atler this certificate has by the funeral director, page 2	2	1 ☐ Yes 2 No	Hospital: 1 Inpatient		R/Outpatier		Other:	4 🗀 (40)		ne 5 Des				')	
בַ	ing P Viter t	ü	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury		Injury a Work?			8d. Describe	how injur	ry occurre	ed		
sio	death. ctor: A y the fu	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be						s 2 N							
Division of	after d Direct Jin by	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	y - At hon <i>(Specify)</i>	ne, farm, str	eet, factory, of	fice		2		(Street an own, State		or Rura	l Route Numbe	∍r,
_	pital		29a. Certifier 1 Certifying Phy	sicien: To the best of	my know	ledge deat	h occurred at the	se time	date and	I place a	nd due to the	Called(s)	and mar	nor se et	ated	
	e Hospital 24 hours a e Funeral letely filled	edical	(Check out) O Made discal France	iman. O- she bear to -6 -	1 41		4.5 4.5 4.5 4.5				-d - a s.b s	4-1-		1 4		
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Me	29b. Signature and title of certifier	~			29c. Li	cense n	number			29d. Da	te signed	(Month,	Day, Year)	
			1/flillian	- De h	-	; m	0 7) (060	25	4		5/	16/	4	
•			30. Name and address of person who d	ompleted se of dei	ath (Item	23a) (Type,	Print)	1	,		1 1	0 1	•			
	10+1		William P.	ones, "	nD	61	315	hi	ndeg	Si	de 1	Ed	21	076	24	
. 3	Sta		31. Date filed (Month, Day, Year)	32. Registra	s Signati	ure 🕡	Acres	2 8	7							_
	Registi	ar	MANV 1	6 2006 P	MELLE.		STATE OF STATE OF	San Park								

246-44-7505

10e. Street and Number

10a State

Director

MD

Usual Residence of Decedent

10b. County

3210 Orleans Avenue

1 Never Married 2 Married

Prince George's

#5,p	er FD,2	246-44-9	801,								
2006,	drw	Pleas	e Type or	Print in Black In	delible Ink.	Ensure A	All Copies A	re Legil	ole.		
	For		State of	of Maryland / Depa	artment of H	lealth and	Mental Hygi	ene) (16	168	75
	1 - For State Registrar			Cei	rtificate of l	Death	Reg	g. No.		100	, 0
4.9		ame (First, Middle,	Last)				2. Date of Death		Vana	3. Time ot	Death
hysician /Medical		Jerry Fr	anklin H	Forsythe, Sr.			May 12,	² 2006	Year	6:13	Ам
xaminer	4a. Facility Nam	e (If not institution,	give street and nu	imber)	4b. City, Town, or	Location of Deal	h	4c. County	ot Death		
200 m 100 m	3210	Orleans A	lvenue		Forest	ville		Prin	ice G	eorge¹	S
neral	5. Social Securit		5. Sex 1. 1 ★M 2 ☐ F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth (Month, Day,	Year)	Count	lace (State of try) th Care	-

10f. Zip Code

20747

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

10c. City, Town or Location

Forestville

Jan 1, 1933

10g. Citizen of What Country?

Month

29d. Date signed (Month, Dav. Year)

May 16, 2006

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

USA

14. Race - American Indian.

White

North Carolina

Cash

20736

Year

Approximate Interval Between Onset and Death

10d. Inside City Limits

1 ☐ Yes 2X No

Fu Director with the Maryland death within 72 hours after Baltimore, Maryland 21215-0036

t of Health and Mental Hygiene. If itam 27 is marked other then "natural", or itama 23a or 28a-f ehow or other traumatic event, the Medical Examinat must be notified at Pages 1 and 2 should be filed in ment of Health and Mental Hygis ant: if Itam 27 is marked other permit. Page Department of Important: if eny injury of

Physician /Medical Examiner

the attending physicien and hed for use as the burial-transit been signed by the s should be detached page 2 s To the Hospital or Attending Physician: filled in by the funeral director. this After death. within 24 hours after deal To the Funeral Director:

Division of Vital Records, P.O. Box 68760,

by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No It Yes, Give Year or Dates: 1 ☐ Yes 2 🕱 No 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Metropolitan Police 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Robert Forsythe Maggie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bowie, MD 20716 Karen Forsythe (daughter) 2923 November Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place) May 16 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 2006 Cheltenham, MD 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Funeral Service Licenses Gary J. Goff 8125 Southern Maryland Blvd. Owings, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death-but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 55 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Xo ို 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State

Registrar

10

29b. Signature and title of certifier

31. Date liled (Month, Day, Year)

Rene Grace.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2006

32. Registras Signature

9131 Piscataway Road Clinton, MD

29c. License number

D02259

State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yeer Physician 40 AM GOLDM 2006 /Medical 4c. County of Oeath 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Manor Care Nursing Home Potomac Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Minn. | Minn. | July 14: , 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**₺** M 2□ F Massachusetts 82 Yrs 022-18-0321 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or iteme 23s or 28s-1 show the Madical Examinar must be notified at ¥Yes 2 No Washington Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20016 U.S.A. 4201 Cathedral Ave. NW Apt. 512 W Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 AYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married 1 M Tes 2 L If Yes, Give Year or Dates: unknown Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than 'any Injury ex-giber traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) U.S. Dept.of Education Operations Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Levine Nathan Goldman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Ruthellen Rd. Hudson, MA 01749 Susan Cohen- Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5-7-06 Sharon, MA Sharon Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitEdward Sagel Funeral Direction 21. Signature of Funeral Service Licenses any in 1091 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cancer Ana /Medical Oue to (or as a consequence of) Examiner Sequentially list conditions, I any, leading to firm ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 2 Fetal death 3 Ectopic pregnancy Month Day Year be detached for 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No certificate has autopsy performed? 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: မှ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 513/06 00054566 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1220 A Ecert Toppa Road Scienzes Towson, H121286 Suuitha Bhogavilli 32 Registrar's Signature 31. Date filed (Month, Day) State 2006 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of	Marylan		rtment of F	lealth and N Death		iene 0	16	16877
			1. Decedent's Name (First, Middle,	Last)					2. Date of Deat Month	Day	Year	3. Time of Death
	Physicia /Medic		John Peter Gar	cia						5/11/200		7:22P M
	Examin		4a. Facility Name (If not institution,	give street and numb	oer)		4b. City, Town, o	r Location of Death		4c. County	of Death	
			Atlantic Gener				Ber1			Worces		
	Funeral			6. Sex 7. 1 XM 2 □ F	. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign htry)
	Director		172-30-7173 Usual Residence of Decedent		68	Yrs.			12/03/19	37		PA
	and		10a. State 10b. County		10c. Cit	y, Town or Lo	ation				1	0d. Inside City Limits
	Mary f sho	ō	MD Worces	tor	000	ean PIr	AC					1 ☐ Yes 2√∑No
	the 28a	Funeral Director	10e. Street and Number		000	-an 111	10f. Zip Code		10	Og. Citizen of W	hat Coun	itry?
	3a or		16 Federal Hil	1			21811			USA		
	death	nera	11. Marital Status		ent Ever in U.	S. 13. V		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race		an Indian,
9	after or Ite	Ē	1 ☐ Never Married XX Marrie	12. Was Deced Armed Force 1 Tes 2 If Yes, Give	MO No			Specify:Span			k, White, Whit	
93	ours iral',	d by	3 Widowed 4 Divorced	Year or Dat	es:		ATT 163 ZITINO	эреспу. эрин		Specify:	WIIIC	
5-(72 h "natu	Completed	15. Decedent's (Specify only highest	s Education grade completed)		16a. Deced (Give	ent's Usual Occup kind of work done	ation during most of work d)	ring	16b. Kind of Bu	siness/Ind	dustry
2	within ne. han	ld l	Elementary/Secondary (0-12)	College (1-4	lor 5+)			1)		HC C		
70	illed v Hygie ther t nt, In		17. Father's Name (First, Middle, L	ast)		Const	1tant	18. Mother's Name	e (First Middle N	US Gove		ent
anc	d be f antal l ced o	Be c	John Peter Garc					Rose Eve		aldon Camam	-/	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u>۲</u>	19a. Informant's Name/Relationsh			19b. Mailin	Address (Street	and Number or Run		City or Town, 5	State, Zip	Code)
<u>∞</u>	nd 2 :: Ith ar 27 is r trau		Jane Garcia (s	nouse)				1 Ocean P			,	,
อ์	s 1 au f Hea item othe		20a. Method of Disposition			lace of Dispos	sition (Name of satory or other place			20c. Location - (City or To	wn, State
e e	Page ent o nt: If		1 ☐ Burial XX Cremation 1 ☐ Donation 5 ☐ Other (Sp	3 □Removal from St ecify)	ate		open Cre	,	/2006 E	rankfor	d. I	Œ
Baltimore,	mit. Joartm sorta sorta / inju		21. Signature of Funeral Service L		, -		_	ss of Facility Bur			_	
ä	Departing Department of the policy of the po		Tarricling	4 Ka	Deat.	1. 10	8 Willia	m Street	Berlin,	MD 2181	.1	
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cau	the deat							Approximate Interval Between
	Physician :		Immediate Cause (Final disease or condition	407	rension							Onset and Death
2	/Medical		resulting in death)		as a conseq	uence of):					_	icars
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	φ =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury	Due to (or	r as a conseq	uence of):						
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S 50 6	eath certificate be executed attending physician and for use as the burial-transit		ing in down, and	O) of euc	r as a conseq	uence or):						
1913.n 2006 18760,	cate physi	Physician/Medical	`	d.								
3-11-3x	ding	/Me	IF FEMALE:	23c. If yes, outco	ome of oregna	incv				224 Date	6 . 4 . 1	
5-11-8 Box	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birt	h 2 Feta	ideath 3	Ectopic pregnancy Other (specify)	•		23d. Date Mon		Day Year
. 0	that the deathed by the atte	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknov		Ja 5	Curior (appeary)	-				
کن گ ^{یو} د	es that the d igned by the be detached		Part II. Other significant condition	s contributing to dea	th but not res	ulting in the ur	derlying cause giv	en in Part I.	23e. Did tob	acco use contri	bute to th	e cause of death?
5 3 E	- W	d by							1 □ Ye	s 2 No	3 🗋 Prob	ably 4 \textcal{Dunknown}
3 Coord	law requas been 2 should	Completed							24a. Was an	24b. W	ere autor	osy findings available
	sician: The lav certificate has rector, page 2	mo							autopsy perform		rior to con eath? □ Yes	npletion of cause of
Ohry Oly Ital F	an: 'tifica tor, p	Be C	25. Was case referred to medical					26. Place of Deatl		A	1 1 9 2	2 140
10-	Physician: this certific ral director,	To E	examiner? 1 □ Yes 2 No	Hospital: 1 □ Ing	patient 2	ER/Outpatien	3□ DOA Oth	er: 4 🗆 Nursing Ho	me 5 Reside	nce 6 Othe	r (Specify	')
مري و			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe hor			
Sarci 192	Attending r death. ector: After by the fune	satlo	2 Accident investiga	ation				Yes 2 □ No				
Garci 192	trer de lirect	Certification:	3 Suicide 6 Could no 4 Homicide determin	ned 286. Place o	f Injury - At ho , etc. <i>(Specif</i>		et, factory, office		28f. Location (Str. City or Town,	eet and Numbe State)	r or Rura	l Route Number,
	ie Hospital or Attendi 124 hours after death ie Funeral Director: A pletely filled in by the fi		00-0-46-	Ph								
	Hosi 24 ho Fune stely f	edical	29a. Certifying (Check only one) Certifying Medical E	Physician: To the b xaminer: On the bas and manne	is of examina	wledge, death tion and/or inv	occurred at the tir estigation, in my o	ne, date and place, pinion, death occurr	and due to the ca red at the time, da	use(s) and man te and place, ai	ner as stand due to	ated. the cause(s)
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Med	29b. Signature and title of certifier	and manne	a stateu.		29c. Licens	e number	29	d. Date signed	(Month, L	Day, Year)
	⊢≯⊢ŏ		N X M	0			MD	0006345			, 200	
			30. Name and address of person w	no completed cause	of death (item	23a) (Type. I					1 200	*
ET	20		Munna Gary, MD	11107 Rac	elacu	Rel.	Berlin, 1	11815 01				
	Sta		31. Date filed (Month Day, Year)	32. 50	gistrar's Signa	ture:	relie	7. 1				
	Registr	ar	MAY 1 6	2006	we.	19						

		•	For State Ragistrar	State of M	aryland / Dep <i>Ce</i>	artment of I rtificate of		Mental Hy	giene 0 0	6 16878
1	Physici	_	1. Decedent's Name (First, Middle, Las Michael Vince		III			2. Date of De Month May 10	Day Ye	3. Time of Death 5:14P
).	/Medic Examir	200	4a. Facility Name (If not institution, give Montgomery Gener	street and number		01r		ath	4c. County of Montgo	Death
nger	Funeral Director		5. Social Security Number 6. Security Number 219-68-7396 Usual Residence of Decedent	X 7. A(ge (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Da	orth ay, Year) 25, 1957	Birthplace (State or Foreign Country) Maryland
	Maryland a-f ehow	tor	10a. State 10b. County Maryland Montgom	ery	10c. City, Town or Le	eville				10d. Inside City Limits 1 X Yes 2 □ No
	with the	i Director	10e. Street and Number 2700 Civitan C	lub Place		10f. Zip Code	0833	II	10g. Citizen of Wha	t Country?
9036	n 72 hours after death with the Maryland "neturel", or items 23a or 28a-f show patest Exeminet must be notified at	t by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 X If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (an, Mexican, Pue			American Indian, White, etc. White
21215-0036	I within 72 liene. r than "ne ine Medic	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) Coltege (1-4or 2	5+) (Give	dent's Usual Occul kind of work done DO NOT use retire	during most of we		L	ess/Industry verings & leling
Maryland	9 2 2 5	To Be	17. Father's Name (First, Middle, Last) Michael V. Ga				Jud	lith Lee		
	Pages 1 and 2 should be nent of Health and Ment int: If item 27 ie markec iry or other traumatic e		19a. Informant's Name/Relationship (7 Deborah Susan Gar 20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 □	gan - Wif	e 2700 20b. Place of Disp	Ocivitan District (Name of matory or other pla	Club Pl		onkeville, 20c. Location - Cit	MD 20833 y or Town, State
Baltimore,	permit. Pa Departmen important: eny injury once.		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen		2	2. Name and Addre	ss of Facility H i	nes Rina	ıldi Funer	d, Maryland al Home, Inc. ing, MD 20904
## *	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or component shock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as c.	Asysto	ler the mode of dyn Re ny Ocard artery				Approximate Interval Between Onset and peath I MME VIEW E 10 Days years
P.O. Box 68760	death certificate e attending phys od for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 □ Yes 2 No 9 □ Unknown		2 Fetal death 3	⊒Ectopic pregnanc	у		23d. Date of Month	f delivery Day Year
	law requires that the es been signed by th 2 should be detache	by	Part II. Other significant conditions on hyperlipider	·	put not resulting in the u	inderlying cause gr	ven in Part I.			te to the cause of death? Probably 4 Onknown
of Vital Records,	The la	Completed	sancocosi	٤				24a. Was auto perfe 1 🗆 Yes		
	Attending Physician: Trideath. In death. In death. Still this certificel by the funeral director, p.	ation: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpati	ury 28b. Time o	of 28c. Inju	ner: 4 Nursing		one) dence 6 Other (how injury occurred	Specify)
Division	s after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of in	jury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (City or To	Street and Number own, State)	or Rural Route Number,
	To the Hospital or Attending PP within 24 hours after death. To the Funeral Director; Atter th completely filled in by the funeral	edicai	29a. Certifier 1 Certifying Ph. (Check only one)	ysician: To the best iner: On the basis and manner s	of my knowledge, deal of examination and/or in tated.	h occurred at the ti	me, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
	To the To the complet	Σ	29b. Signature and title of certifier	nard		29c. Licen	2879	1	May 12	onth. Day, Year)
	V		30. Name and address of person who	hulin Dr	Diney	(MI)	20832	LEONAR	B, M.D.	
	Sta Registi		31. Date filed (Month, Day, Year) AN 15	2006 32. Regist	rar's Signature	Gentle				

		4	For State Registrar	State of N	Maryland	•	rtment of H		_	giene Reg. No. 00	6 16879
	Physici	an	1. Decedent's Name (First, Middle, I		th Gra	av			2. Date of De Month		'ear 3:04 A M
	/Medic Examin		4a. Facility Name (If not institution, g		r)		4b. City, Town, or Pril	Location of Dea	ıth	4c. County of	
	Funeral Director				Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Da	th (y, Year)	Birthplace (State or Foreign Country) Maryland
	anyland show		Usual Residence of Decedent 10a. State 10b. County MD C	alvert	10c. City	, Town or Lo		St. Leonard	1		10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	with the M a or 28a-f be notified	Director	10e. Street and Number 2585 Lloyd Bowen Road				10f. Zip Code	20685		10g. Citizen of Wh	at Country? J.S.A.
036	be filed within 72 hours after death with the Maryland ital Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examinant and be notified at	by Fur	11. Marital Status 1 □ Never Married 2 □ Married ★□ Widowed 4 □ Divorced	12. Was Deceder Armed Force	s?] No	i	Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (h, Mexican, Pue Specify:	Specify Yes or No no Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. Black
21215-0036	I within 72 horiene. Iene. r than "naturi ine Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		r 5+)	(Give	lent's Usual Occupa kind of work done d DO NOT use retired, Dom	uring most of w	orking	16b. Kind of Busin	ness/Industry e Else's Home
	2 should be filed within and Mental Hygiene. Is marked other than sumatic evant, the Ma	To Be C	17. Father's Name (First, Middle, La	Joseph Stra	aiten			18. Mother's Na		Maiden Sumame) ances Brown	
Maryland	s 1 and 2 should f Health and Mer itam 27 is marke other traumatic		19a. informant's Name/Relationship Joyce Parran/Daughte				g Address (Street a Lloyd Bowen			ar, City or Town, St 20685	ate, Zip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 I any injury or othar tre once.		20a. Method of Disposition ★□ Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spe		te C6	emetery, cren	sition (Name of natory or other place lemorial Garde		Date 5/18/06	20c. Location - Ci	ity or Town, State at Mills, MD
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lie	a. Sewer	el	22	Name and Addres. Sewell Fu 1451 Dare			rederick, MD	20678
	The law requires that the death certificate be executed XE XE XE XE XE XE XE XE XE X	dicai Examiner	23a. Pant1. Enter the disease, or composed shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the conditions of any, leading to introduce the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a consequence a consequence as a consequence according to the consequence as a consequen	rence of):	atanction	, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
.O. Box 6	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
Q	quires that t in signed by uld be deta	by	Part II. Other significant condition	s contributing to death	6.1	ılting in the uı	nderlying cause give	n in Part I.	23e. Did t	1	ute to the cause of death?
Vital Records,		Completed							24a. Was autoj perfo 1 🗆 Yes	prior prior dea	ore autopsy findings available or to completion of cause of ath?
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	31		Othe	r	eath (Check only o		(0.10)
of	al or Attending Physication of the safter death. I Director: After this d in by the funeral di	ation: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investiga	28a. Date of li (Month, i		ER/Outpatien 28b. Time of Injury	28c. Injury Work	at Nursing	-	dence 6 ⊡Other how injury occurred	
Division	Hospital or Att 14 hours after de Funeral Diract tely filled in by t	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 288. Place of	Injury - At ho etc. <i>(Specif</i> y	me, farm, str	eet, factory, office		28f. Location (City or To		or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medicai	(Check only 2 Medical Ex	Physician: To the be caminer: On the basis and manner	of examinat		vestigation, in my op	inion, death occ		date and place, and	d due to the cause(s)
	vith To con	2	29b. Signature and title of certifier	of Tanko	20		29c. License			29d. Date signed (
	2		30. Name and address of person M.D. David J. Tardio, M.D.	. Prince Frede	rick, MD	20678					
	Sta Regist		31. Date filed (Month, Day, Year) MAY	32. Regi	star's Signat	, J	Grade				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Alicia Greig 05 04 /Medical 2006 7:32 P^{M} Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 524 Forest Hill Drive Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth

| Dave Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1□M XXF Months Days 219-03-0797 Director Yrs. May 16, 1933 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show idical Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes XXNo 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 524 Forest Hill Drive 21403 Items 23a USA death Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after of ment of Heelth and Mental Hygiene.
ant: If item 27 le marked other then "neturel", or Iter ury or other traumatic event, the Medical Examinat Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No 3 X Widowed 4 ☐ Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Manager Masonry Contractor 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) James N. Greenwell ္ဂ Ann M. Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Murielee Kelsey (Daughter) 524 Forest Hill Drive, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Depertment of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 5-11-2006 Baltimore, MD 21. Signature of Funeral Service 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Server Corcinone /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ettending physicien and for use as the buriel-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month 5 Other (specify) Day Year 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 1 No or Attending Physiclen: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ဥ Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA t) After thi 27. Manner of Death 1 @Natural 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. I Director: / 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funerel C completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2411 West Belvedere tre MUB206 52/4 MM 21215 32 Registrar's Signature State Registrar

			For State of Registrar	Marylan		artment of He rtificate of De			eg. No. 200	6 688
	Physicia		1. Decedent's Name (First, Middle, Last) Elton Herman					2. Date of Dea Month May 10,		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and numb	ier)	. ,,,,,	4b. City, Town, or Lo Bethesda	ocation of Death		4c. County of D	
**	Funeral Director		577-42-0591 ¹₽M 2□F	Age (In yrs. 73	last birthday, Yrs.	If Under 1 Year	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 14	Year) 9. I	Birthplace (State or Foreign Country) ashington, DC
	hyland show		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or L	ocation				10d. Inside City Limits
	th the Ma or 28a-f	Funeral Director	MD Montgomery 10e. Street and Number	Po	tomac	10f. Zip Code	•	1	0g. Citizen of What	1 Yes 2 No Country?
	eath wil	erai C	12005 Coldstream Drive	ent Ever in U	S 13	20854	anic Origin? (Sp	ectiv Yes or No-	U.S.A.	merican Indian,
036	72 hours atter death with the Marylan Insture!, or Iteme 23a or 28a-1 ehow Idical Examiner must be notified at	þ	Armed Forc 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give Year or Dat	es? 1ਓ7]No	.0.	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No	Mexican, Puerto Specify:	Rican, etc.)	Black, W Specify: V	hite, etc.
215-0	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. ie marked other than "naturel", or Iteme 23a or 28a-f ehow reumatic event, the Madical Examine must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	lor 5+)	(Give	dent's Usual Occupation wind of work done during DO NOT use retired)	on ing most of work	ing	16b. Kind of Busine	
d 21	be filed within ital Hygiene. Id other than event, the Ma	Be Cor	17. Father's Name (First, Middle, Last)		Phys	sician 18	3. Mother's Nam	e (First, Middle,	U.S. Gov Maiden Sumame)	rernment
ylan	ould be Mental Marked Maric ev	To B	Louis Herman				Celia B			
Mar	nd 2 sh aith and 27 ie m r treum		19a. Informant's Name/Relationship (Type, Print) Laurence A. Herman-Son			ing Address (Street and Kennebec Av				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 ie merked eny injury grotther treumatic ev once.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from St 4 □ Donation √5 □ Other (Specify)	ate	-	osition (Name of matory or other place) emorial	5-14-		20c. Location - City Olney, MD	or Town, State
Balt	permit. Departr Imports eny inj		21. Signature of Funeral Service Licensee			^{2. Nam} Daniždins i 170 Rockvii				
	Physician		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition	used the death th line. diogen:			such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death 12 hours
073	/Medical Examiner		Due to (or	r as a conseq	uence of):	myopathy				30 Years
27.	scuted nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	r as a conseq	uence of):	шуораспу				Ju Tears
2006	ficate be executed physician and s the burial-transit	edicai Ex	Due to (or	r as a consequ	uence of):					
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and . 2 should be detached for use as the burial-transit	Physician/Me		th 2 ☐ Feta nt at time of d	death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
) / (rds, P.	quires that I n signed by uld be deta	þ	Part II. Other significant conditions contributing to dea Ehlers-Danlos Syndrome	th but not res	ulting in the i	underlying cause given	in Part I.			e to the cause of death? Probably 4 □Unknown
$Elto_{\cal M}$ ital Record	Physician: The law red this certificate has bee al director, page 2 sho	Completed						24a. Was a autops perfori	y prior	
$\mathcal{L}_{\mathcal{L}_{\mathbf{I}}}$	Physician: rthis certifica ral director, p	Be	25. Was case referred to medical examiner? Hospital:			100		h (Check only or	16)	
Herman, Division of Vi	ting I. After funer	tion; To	27. Manner of Death 28a. Date of	Injury Day Year)	28b. Time of Injury	of 28c. Injury at Work?			ence 6 Other (S	pecify)
الاسم Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Place o	I Injury - At ho		reet, factory, office		281. Location (Si City or Town	reet and Number or n. State)	Rural Route Number,
He	the Hospit hin 24 hours the Funera upletely fille	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner and mann	is ol examina						
		¥	29b. Signature and title of certifier Michaela. Weste	man	M.D.	29c. License n D52451	umber	2	9d. Date signed (Mo May 10, 2	
	Ì		30. Name and address of person who completed cause Michael A. Westerman, M.I				500 014	Georgeta	own Rd.Ret	20814 Thesda.MD
	Sta		Michael A. Westerman, M.1 31. Date filed (Month, Day, Year) 32. Reg	gistrar's Signa	iline	es l		Storgor		
	Registi	वि	HILL TO TOOL TO	1500	1					

文化 (A)

DHMH 17 Rev 1/2001

State 31. Date filed Registrar

31. Date filed (Month, Day, Year)

32. Registrar Signature

H. Sperke

ompleted cause of death (Item 23a) Type, Print), Sulfe 212 Prince Frederick, MD

DO05906/

Amend # 20th per FD 5-22-06 A.A.Co.Health Dept. PM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	1 - For State Registrar	State of Marylar	nd / Dep	artmer		and M	ental Hyg		006	16883
	Physici /Medic Examin	al	1. Decedent's Name (First, Miedle, Last) 4a. Facility Name (If not institution, give s 1153 Marlboro R		HA		Town, or Location	on of Death	2. Date of Dea Month M Ay	4c. (Year OG County of Dear ne Art	th
	Funeral Director		5. Social Security Number 218-76-2118 6. Sex Usual Residence of Decedent	7. Age (In yrs.	last birthday) 89 Yrs.	If Unde Months			8. Date of Birth (Month, Day Aug 30	Year)	9. Bin	thplace (State or Foreign ountry) ryland
	he Maryland 28a-f show	ector	10a. State 10b. County Anne Ar 10e. Street and Number		othia	n						10d. Inside City Limits
	s 23a or	Funeral Director	1153 Marlboro R			2	20711			U	en of What Co	
900	72 hours after deeth with the Maryland naturel', or Itama 23a or 28a-f show Jigal Examinat muat be notified at	d by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			dent of Hispanic (ocify Cuban, Mexic		city Yes or No- Rican, etc.)		4. Race - Ame Black, Whit Specify: B	te, etc.
21215-0036	within ane. than	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 8th		(Give	kind of wi DO NOT i	ial Occupation ork done during m use retired) 1aker	nost of workir	ng		d of Business	/Industry
Maryland ?	should be filed nd Mental Hygi marked other Imatic avent, II	To Be C	17. Father's Name (First, Middle, Last) Bernard Sellman					Emily	(First, Middle, Sellm	an		
	i and 2 sh lealth and im 27 is m		19a. Informant's Name/Relationship (Type Carol Johnson (Da	ughter)	844	Hour	s (Street and Nun	Lane	Lothia	n,	Md. 20	0711
Baltimore,	permit. Pages 1 Department of H Important: If ite any njury or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)	Re		ctic	n Cem	5-13-0 5-1	6 2-06	Cli:	ation - City or nton,	Md.
Bal	Departing on the control of the cont		21. Signature of Funeral Service License	rear MOOG	83 8	2 Name a M . F 21 V	nd Address of Fac leese & lest St	Sons Ann	Mortu apolis	ary , M	á. P.A.	401
	Physician /Medical Examiner		23a. Part! Enter the disease, or complie shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	uence of):	247	de of dying, such ZET (ALCIN	PAST	auc 77			Approximate Interval Between Onset and Death
3760,	ste be executed hysician and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	juence of):							or it sylvan
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al Records,	iclen: The law requires that the certificate has been signed by the ector, page 2 should be detache	Completed							24a. Was a autops perform	y ned? No	prior to death?	atopsy findings available completion of cause of
of Vital	9 4 5	To Be	1 165 21 110		ER/Outpatier		OA Other: 4	Nursing Hom	Check only on	nce 6		cify)
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Ο̈́	P Sign		4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	(y)		٠.		City or Towr	, State)		ıral Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	one) - 2 Medical Examin	ician: To the best of my knoter: On the basis of examinating and manner stated.	ition and/or in	vestigation	n, in my opinion, d	leath occurre	d at the time, d	ate and p	place, and due	to the cause(s)
	V Wit		29b. Signature and title of certifier	1 M	2/1	les	c. License numbe	438		Mr	signed (Mont) Hy	9 7 20
			MICHAEL Lat	releted cause of death (Iter	745	DEFE	ENSE	High	WAY	A	NNAPI	ous Moziyy
	Sta Registr	-	31. Date filed (Mexically, Year) 200	Begistrar's Signature	y" A							

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland		nt of Health ar	•	giene Reg. No.2 0 0 G	16884
	Physici /Medic	_	1. Decedent's Name (First, Middle, Last)	ENKINS			2. Date of Dea	Day Year	3. Time of Death
	Examin Funeral	er	4a. Facility Name (If not institution, give s ACT OF Social Security Number 6. Sex	ospital		y, Town, or Location of der 1 Year II Under 24 s Days Hours	Hrs. 8. Date of Birt	4c. County of Dec	rthplace (State or Foreign
5	Director Maryland Money Money		Usual Residence of Decedent 10a. State 10b. County Talba	10c. City,	Town or Location		Sept.	0,1897 1	10d. Inside City Limits 108Yes 2□No
3	th with the P 23e or 28e-	al Director	10e. Street and Number	Street Apt	405	Zip Code 2/60/		10g. Citizen of What C	Country?
036 N	hours after death with the Maryland turel', or Items 23s or 28e-f ehow al Exercises be notified at	by Funeral		2. Was Decedent Ever in U.S Armed Forces? 1		pedent of Hispanic Origin becify Cuban, Mexican, 202 No Specify:	n? (Specrfy Yes or No Puerto Rican, etc.)	- 14. Race - Arr Black, Wh	
21215-0036	d within 72 piene. r then "nei	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	A	sual Occupation work done during most of use retired)		16b. Kind of Busines	HOME
Maryland	d 2 should be filed th and Mental Hygi 7 Is marked other traumatic event, I	To Be C	17. Father's Name (First, Middle, Last) Harvy Tha 19a. Informant's Name Relationship (Ty)		OCE, SR	1	s Name (First, Middle,	Butler	Zin Code)
-	of Heal of Heal if item 2		(0)	ndy 20b. Pla	ace of Disposition (A metery, crematory o	te St. A	Pt. 405 E	Easton 1 20c. Location - City of	M D . 21601
Baltimore	permit. Pag Department Important: eny injury c		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	Henry	22. Name HeN	and Addr's of Facility RY FUNERO NIA Shings	Home, P.	imbridae	
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		Do not enter the m	ode of dying, such as ca	ardiac or respiratory ai	rrest,	Approximate Interval Between Onset and Death
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	he Hospl in 24 hour he Funer pletely fill	edicai		sician: To the best of my knowner: On the basis of examination and manner stated.					
	To t To t	Σ	29b. Signature and title of certifier Chocycome	MX		29c. License number 043261		29d. Date signed (Mor	•
			30. Name and address of person who co	mpleted cause of death (Item 219 S- WASH)	23a) (Type, Print)	, EASTON, 1	us	1.0/20	
	Sta Regist	ate rar	31. Date liled (Month, Day, Year)	006 32. Palistrar's Signatu	A Some	W			

		For State Ragistrar	State	of Maryla		artment of F rtificate of			lental H		ne No.20	06	15	885
		1. Decedent's Name (First, Middle	e, Last)						2. Date of	Death	Davi		3. Time o	f Death
Physicia /Medic		Evelyn Aileen K	rantz						Month May 2	21.	Day 2006	Year	6:30	РМ
Examin		4a. Facility Name (If not institution		umber)		4b. City, Town, o	r Location	n of Death	114)		4c. County	y of Death		
		Heartfields of	Frederic	k		Frederic	k			-	Frede	rick		
Funeral		5. Social Security Number	6. Sex		rs. last birthday)	If Under 1 Year	If Unde	er 24 Hrs.	8. Date of	Birth		9. Birth	piace (State	or Foreign
Director		220-10-5022	1 □ M 2 💢 F		91 Yrs.	Months Days	Hours	Min.	Feb.	Day, Yo	1915		land	
		Usual Residence of Decedent												
how	_	10a. State 10b. County		10c.	City, Town or Le	ocation							10d. Inside C	•
Ma-t-	5	Maryland Fred	erick		Frede	erick							1)() Yes	2 🗆 No
5 th	Director	10e. Street and Number				10f. Zip Code				10g	. Citizen of	What Cou	intry?	
15 wi		1820 Latham	Drive			21701				US	A			
de e	Funerai	11. Marital Status	12. Was De	cedent Ever in	1 U.S. 13.	Was Decedent of H	lispanic C	Origin? (Spe	ecify Yes or	No-		ce - Amer	can Indian.	
afte afte	4	1 Never Married 2 ☐ Marr		2 X No		1 ☐ Yes 2 🗓 No					Specif		. 610.	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiane. Important: it farm 27 is marked other than "natural", or itama 23e or 28e-t ahow any injury or other traumatic event, the Madical Examiner must be notified at one.		21. Signature of Funeral Service	Cicensee /		2:	2. Name and Addre	ss of Fac	ilityKeer	ney ar	ıd Ba	asfor	d Fur	eral H	lome
707 g d		23a. Part1 Enter the disease, or	Skan	J pr. C. 1		06 East (k, MI	2170)1
cate be executed /Medical Examiner physicien and the burial-transit	dicai Examiner	show, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	Alzhei o (or as a cons	sequence of): $c\ 1\ r\ o\ t\ i$ sequence of):	isease c Cereb	rova	ascu l	lar D	ise	ase		Interval Be Onset and y e a r s	Death
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nding I th. :: After s funer	at o	1 Natural 5 Pendin 2 Accident investig	9	onth, Day Year) Injury		k? Yes 2.[□No						
To the Hospital or Attending Physicien: within 24 hours efter death. To the Funeral Director: After this certifica compietely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could of determined	ined 286. Pta	ce of Injury - A ding, etc. (Spe	t home, farm, str	reet, factory, office			28f. Locatio City or	n (Stree Town, S	et and Numb State)	per or Run	al Route Num	iber,
a Hospital	edical (29a. Certifier (Check only one) 1 Certifyin 2 Medical	Examiner: On the	he best of my basis of exam inner stated.	knowledge, deat ination and/or in	h occurred at the tin vestigation, in my o	ne, date a pinion, de	and place, a	and due to t ed at the tin	he caus ne, date	e(s) and ma and place,	anner as s and due t	stated. the cause(s	s)
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;	ŀ	30. Name and address of person	no completed car	use of death (I	tem 23a) (Type	Print)	-0-			I.	iay 4	٠, ١	.000	
6		Dr. Allen J.	Gilson			Taney Av	re #	2.04	Fred	leri	ick M	ID 21	1702	
Sta		31. Date filed (Manth Day Year)		Registrar's Si			<u> </u>				11	- 4	. 0 4	
Registr	A 8	mai o o co	U ALKAMA		-	-								

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistraMEND#5perINF5/23/06,BMW,MbCo Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 14, 2006 5:38 a M May 0. Ludington Georgia /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery General Hospital Olney | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 29, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□M 2MF Yrs. 1922 Missouri 83 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
Interpretatif It leam 27 is marked other then "neturel", or Items 23a or 28a-1 ehow improrant; If them 27 is marked other then "meture", or Items ar must be notified at once. 1 ☐ Yes 2 🕱 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 USA 3450 Glen Eagles Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Speciathite by 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel J. O'Connor Ruby M. Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 821 McCeney Avenue, Silver Spring, MD 20901 Alice E. Ludington/ Daughter Date 14, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2006 Alexandria,~Virginia 21. Signature of Funeral Service Licensee Francis do Tvins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each fine. Immediate Cause (Final disease or condition SEDSTS **Physician** resulting in death) /Medical Due to (or as a consequence of) tract intection Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit emeu the attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ğ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 1 Yes 2 12 No or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 1 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) I in by t 4 Homicide pellil Hospital Medical 29a. Certifier to the cause(s) and manner as stated. mpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the } 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day,

2006

			1 10430	State of Manua					-		_	-	
			1 - For State Registrar	State of Maryla	_		te of L		wentai H	ygrene Reg. No.	200	6 160	97
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	Physicia /Medic		Rita Lipson						Month May	11	, Ye	20069:05P	М
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. Cit	y, Town, or	Location of Dea	ith	4c.	County of E	Death	
	V 6	×	1801 E. Jeffers				Rockv	ille If Under 24 Hr			Montgo		
	Funeral Director		5. Social Security Number 6. S 101-03-5467	TM 2TE	rs. last birthday 95 Yrs.	Month		Hours Mir		ay, Year)	1010	Birthplace (State or I	Foreign
*			Usual Residence of Decedent	Λ	90				sept.	21,	1910	New York	
	nylan nhow	_	10a. State 10b. County	10c.	City, Town or L	ocation						10d. Inside City	
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	be filed within 72 hours after deeth with the Maryland Hygiene. d other than "natural", or itama 23a or 28e-f ahow avant, the Madical Examiner must be notified at	Funeral	1801 E. Jefferson	Street, # 21 12. Was Decedent Ever in		Was Dad	208		Specify Yes or N		U.S.	American Indian.	
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5	ours a	ρ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2 X No	Specify:			Specify:	White	
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Z .	and 2 selth a n 27 l		Lois Tuwiner - D	aughter	356	Broa	dview	Lane,	Annapoli	s, M	ary1ar	nd 21401	
saimmore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelih and Menlet Hygiene. Important: If team 27 is marked other than "natural; or Itama 23a or 28e-1 ahow any injury or other traumatic avant, the Madical Examiner must be notified at once.		20a. Method of Disposition 1 ∏ Burial 2 ☐ Cremation 3 ▼		. Place of Disp cemetery, cre	osition (Namatory of	ame of other place	θ)	Date	20c. Lo	cation - City	or Town, State	
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מ	Depar mpor mpor nny in		21. Signature of Funeral Service Licer	See	Ed	2. Name lward	and Addres Sage	is of Facility 1 Funer	al Direc	tion	, Inc.		
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5	ital o	Cer											
	To the Hospital or Attending Physician: within 24 hours defer death To the Funeral Director: After this certified completely filled in by the funeral director, to	edical	Check only 2 Meancar Exam	ysician: To the best of my hiner: On the basis of exam	nowledge, dea ination and/or i	th occurre	d at the tim	ie, date and place	e, and due to the	cause(s)	and manne	r as stated. due to the cause(s)	
	tha thin 2 tha mplel	Med	29b. Signature and title of certifier	and manner stated.			9c. License					Ionth, Day, Year)	
	F3F8		· (11110					6495					
	5		30. Name and address of person who	completed cause of death (I	tem 23a) (Tyne	, Print)	זת	U47J		Ma	ay 12,	2000	
22			Dr. Joel L. Goo	zh 6410 Rock	ledge I	rive	, Sui	te 401,	Bethesd	a, Ma	arylan	id 20817	
	Sta		31. Date filed (Month, Day, Year)	2006 32. Figistrar's Sig	mature	god	A.						
	Registr	ar	MAY I	CUUU ARREST		-							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? For State Registra/MEND#20bperFH5/16/06,BMW,McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** a M Lester Melvin Leach May 2006 9:51 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring M If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Holy Cross Hospital Montgomery

9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F Director 185-24-4131 75 Sep. 7,1930 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Deperment of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or teme 23a or 28e-1 ehow amy houry or other treumatic event, it a Madical Eminiar mail the mittling an once. 1 Yes 2 No Directo Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12340 LaPlata Street 20904 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) Technician **Electrical** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Oren Leach Charlotte Flood 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Leach Wife 12340 LaPlata Street Silver Spring, Maryland 20904 Baltimore, 20b. Place of Disposition (Name of competery, crematory or other place)
Grand View Memorial
Park Date 17 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 16,2006 Annville, Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 RU Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician _{a.} <u>Alzheimer's Disea</u>se /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours eliter death.
To the Funeral Director: After this certificate hes been signed by the ettending physicien end completely filled in by the tuneral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2x No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 K No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 K Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗍 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 5+ D 52261 May 12, 2006 111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan R. Segal, M.D 1517 Hugo Circle Silver Spring, Maryland 20906 32. egistrar's Signature 31. Date filed (Month, Day, Year) State 15 5008 Registrar

				State of	Maryland	/ Depa <i>Cer</i>	irtment of h <i>tificate of</i>	Health and <i>Death</i>	d Mental Hy	rgiene	06	16889
			1. Decedent's Name (First, Middle	le, Last)					2. Date of Do Month	eth Day	Year	3. Time of Death
	Physici /Medio		Gladys Louis	e MacCumbe	ee				May	22. 20		7:25 PM
	Examin		4a Facility Name (If not institution	n, give street and nun	nber)			4b. City, Town,	or Location of Dea	th 4c. County		
		Ġ.	Julia Manor					Hagers			ingto	n
Ī	Funeral Director		5. Social Security Number 214–34–0387	6. Sex 1 □ M 2√2 F	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 i	Ain. (Month, D	rth ay, <i>Year)</i> 12 ,1 935	9. Birthpla Country	ce (State or Foreign y) A
	D .		Usual Residence of Decedent									t I
	show thow	_	10a. State 10b. County		10c. City, T		cation				100	f. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f	5	MD Washi	ngton	Har	cock	1.00 50 50			45 0'''	W	
	th th	F	10e. Street and Number	1			10f. Zip Code			10g. Citizen of V	vnat Country	y r
	ath v	a.	13916 Maple Ri		dent Ever in U,S.	12 1	21750	Hispania Origin	2 (Specify Ves or N	USA	e - Americar	Indian
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Manyland Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at once.	by Funeral Director	11. Marital Sfatus 1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	ried Armed For	rceş? 2[X No e		Yes, specify Cub	an, Mexican, Pi	? (Specify Yes or Nuerto Rican, etc.)		White, et	c.
ဝို	2 hou	8	15. Deceder	nt's Education		16e. Deced	lent's Usual Occup	pation		16b. Kind of Bu	ısiness/Indu	stry
215	nin 7.	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1		life. L	kind of work done OO NOT use retire	durin g most of d)	working			
7	d with	E	12	Conoge (1	401017	Mana	ager			Retail	Sales	
g	othe Vent,	Bec	17. Father's Neme (First, Middle,	Last)			_	18. Mother's	Name (First, Middle	, Maiden Sumam	10)	
la	should be and Mentel	၉	James Jordan						se Hoopen			
a.	2 sho end is me		19a, Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (Street	t and Number of	r Rural Route Numb	per, City or Town,	State, Zip C	Code)
≥,	and safth		Diane Finney/D	aughter		3321	Nationa	al Pike	Hancock,	MD 2175	0	
Baltimore,	of H		20a. Method of Disposition 1 M Burial 2 ☐ Cremation	3 □Removal from 5	State cem	etery, cren	sition (Name of natory or other pla		Date	20c. Location -	City or Tow	n, State
E	permit. Pages Department of 8 Important: If its any Injury or o		4 ☐ Donation 5 ☐ Other (S		St.F	eter'	s Cathol	ic	05/25/06	Hancock	, MD	
Sall	Depart Import any In		21. Signature of Juneral Service	Licensee		22	. Name and Addre	ess of Facility	141 Wes	t Main S	treet	
ш	g ∪ = e a		Kach	X	2-	Gr	ove Fune	eral Hon	ne,P.A. H	ancock.	MD 21	750-0368
	9. 16		23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that ca t only one cause on ea	aused the death. ach line.	Do not ente	er the mode of dyi	ng, such as car	diac or respiratory	arrest,	, A	Approximate nterval Between
	Physician											Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	a	Uterin	11	can	eev				
П	LXuiiiiici	.	resulting in death)		Due to (or a	s a conseq					1	
D.	bed isit	- Pi		b	chro:			0,5	ease		- 1	
h,	en en el-tre-r	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or a						Ī	
68760,	es that the death cardificate be executed igned by the attending physician end be deteched for use es the bunel-transit		cause. Enter Underlying Cause (Disease or injury that initiated events	C			ensio	<u></u>				
89	ficete p phy s the	edical	resulting in death) Last		Due to (or as	s a consequ	uerica dij.				1	
Вох	deeth certif e attending ed for use e	Physician/M		d							-	
Ď	deeth a atte d for	cla	Part II. Other significant condition	ons contributing to de	ath but not resulting	na in the ur	nderlying cause gi	ven in Part I.	23b. Did	tobacco use cor	ntribute to t	ha cause of death?
P.O.	t the	hys				•	,		10	Yas 2□ No	3 Proba	bly 4 Unknown
	s the	by F										(
Records,	.⊑ vs r o	8							24a. Was	s an autopsy ormed?	avail	autopsy findings able prior to
S	aw requis peen	piet							-		of de	pletion of cause eth?
æ	The lew ete hes page 2	Completed							10	Yes 2 No	10	Yes 2□ No
of Vital		Be	25. Was case referred to medica	al				26. Place of	Death (Check only	one)	1	
1	S 0 0	70	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 □ I	npatient 2 EP	NOutpatien	t 3 DOA	her: 4 Nursin	ng Home 5 ☐ Res	idence 6 □Oth	er (Specify)	
	ding Ph h. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pendi	28a. Date of (Mont.	of Injury 28 h, Day Year)	3b. Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe	how injury occurr	ed	
Ö	Attending ir deeth. octor: After by the fune	atic	2 ☐ Accident invest	igation			M 1	Yes 2□No				
Division	or Attendent efter deet Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place	of Injury - At home ng, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location City or To	(Street and Numb wn, State)	er or Rural I	Route Number,
	itai or irs efter ral Dir led in	S		-								
	To the Hospital or Attending Is within 24 hours efter deeth. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical	ng Physician: To the Examiner: On the ba	isis of examination							
	To the within 2 To the comple	¥ ec	one) 29b. Signature and title of certifie	and mann	ier stated.		29c, Licen	se number		29d. Date signed	d (Month, Da	av. Yeer)
D	, C	_	James James of contine	nuly				6039	6	,	23/01	
	/9	`	30. Name and address of person			3a) (Type,	Print) 1,2 6	, ora	it ct		0 -	15.0
			FARIT	222				Hay	RYSTOUN	, Mo	217	70
	Sta		31. Date filed (Month, Day, Year,	2006	egistrar's Signatur	los	de la	7				
	Registr		MAY 3 0	ZUUD JULE	יינ נאט	7						

DHMH 16 Rev 6/95

	-	For State Registrar	State of Marylan			nt of H		nd Me	ntal F	lygiene Reg. No	2000	16890
		Decedent's Name (First, Middle, Last,)					2	2. Date of Month			3. Time of Death
Physici /Media		HOMER A. MC MA	AHON					/	May	, 1ಸ್	2000	20:01M
Examir		4a. Facility Name (If not institution, give		. /	4b. City	, Town, or	Location of	Death	-	1	County of Dea	th
		PENINSULA REGIONA	1.71	V	W I I and	384	361	4 Uro -			Vicinko	(0)
Funeral		5. Social Security Number 6. Set	14 2DE	last birthday) Yrs.	Months	or 1 Year Days	Hours	Min.		Day, Year,) C	thplace (State or Foreign ountry)
Director		579-38-5271 Usual Residence of Decedent	78						1-6-	1928	WAS	HINGTON, D.C.
land ow		10a. State 10b. County	10c. Cit	y, Town or L	ocation							10d. Inside City Limits
Mary 	ţ	DELAWARE SUSSEX	МІІ	LLSBOR	0							1 ☐ Yes 2 🛣 No
r 28a	Directo	10e. Street and Number				ip Code				10g. Ci	tizen of What C	ountry?
h witi	a D	32722 E. ALBEMAR	LE CT.		1	9966				UNI	CED STA	res
dea	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Dec	edent of Hi ecify Cuba	spanic Origi n, Mexican,	n? (Spec Puerto Ri	ify Yes or ican, etc.)	No-	14. Race - Am Black, Whi	
1215-0036 within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f ehow he Medicul Evandrar most be notified at	by Fu	1 Never Married 2 Married	1	_	1 🗆 Yes	21 X No	Specify:				Specify:	Toriz
21215-0036 ad within 72 hours af giene. er then "natural; or t, the Medicul Exem	d b	3 Widowed 4 Divorced 15. Decedent's Edu			dent's Hs	ual Occupa	ation			16b k	(ind of Business	ITE s/Industry
157 n 72 n 158 n 159 n 1	siete	(Specify only highest grad	le completed)	(Give	kind of w		luring most o	of working	7	100.1		
with sene	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	PHOT	OGRAI	HER				PH	OTOGRAP	HY
Hyg ethe	BeC	17. Father's Name (First, Middle, Last)					18. Mother	s Name (First, Mid	dle, Maidei	n Sumame)	
land be denta denta	To B	EDWARD ALBERT MC	MAHON				ADA O	LGA	MELI	CK		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or items 23a or 28a-1 ehow eny injury or other traumatic event, the Medical Exantractment be notified at ance.		19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mail	ing Addre	ss (Street a	and Number	or Rural	Route Nu	mber, City	or Town, State,	Zip Code)
and 2		SHIRLEY . MC MAHO					MARLE				O, DE	
Baltimore, bermit. Pages 1 a Department of Hei important: if Item any Injury or othe		20a. Method of Disposition 1 ☐ Burjar 2 🏋 Cremation 3 ☐ f	20b. F	Place of Disponentery, cre PE HEN	osition (Namatory or	ame of other plac	θ)	Da	te	20c. L	ocation - City or	r Town, State
Pag Pag ment ant: f		4 Donation 5 Donat (Specify)	CRI	EMATOR	LOPEI Y	·	5	-17-	06	FRA	NKFORD,	DELAWARE
Balt permit. Departimport import		21. Signature of Furget Hartvice Livens	see//	1	Z Name	N FUN	NERAL	SERV	ICES,	LTD		10066
m 89729	Ш	CHANNE MIL	pe								LAWARE	T
		23a. Part 1. Enter the disease, or comp shock, or heart fairle. List only of	lications that caused the deat ine cause on each line.	h. Do not en	iter the mo	ode of dying	g, such as ca	ardiac or	respirator	y arrest,		Approximate Interval Between Onset and Death
Pnysician	7. 1	Immediate Cause (Fir aldisease or condition	a Pulmon	ary)	E; 6	VOS.	5					years
/Medical Examiner		resulting in death)	Due to (or as a consec	uence of):								0
Examiner .			b. — Die to (or as a nonsec	uanca offi								
Pa isit	Jine	cause. Enter Underlying Cause (Disease or injury	Die co (or de anories	(dalities City								
xecut and ul-trar	Examin	that initiated events resulting in death) Last	c	uence of):								
18760, cate be executed physicien and the burial-transit	dicai E											
. Box 68760, death certificate be executed e attending physicien and of for use as the burial-transit	edic		0.									
Box 68 leath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		—·.						23d. Date of de	alivery
Geath death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Feta 4□Pregnant at time of c		□Ectopic □ Other (pregnancy specify)				_	Month	Day Year
P.O. that the de	hys	9 ☐ Unknown	9□ Unknown						1	_		
ords, P.O	by P	Part II. Other significant conditions co		sulting in the	underlying	cause give	en in Part I.					to the cause of death?
cord:	ed	Cardiomy	opathy						1	Yes 2	2 □ No 3 □ F	robably 4 Unknown
Recc e law re has be se 2 sh	pie								24a. V	utopsy	24b. Were a	utopsy findings available completion of cause of
I Rec The law ete has b	Completed								1 ☐ Ye	erformed?	death?	s 2□No
of Vital F Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					26. Place	of Death	(Check or	ily one)		
of V hysic this co	2	1 Yes 2 No		ER/Outpatie			4 🗆 (40)				6 ☐Other (Sp.	ecify)
ng P		27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury		28c. Injun Worl			3d. Descri	be how inji	ury occurred	
Division of Vital Records, to Attending Physician: The law requires talter death. Director: Atter this certificate has been signed in by the funeral director, page 2 should be	Certification:	2 Accident investigation 3 Suicide 6 Could not be			M		Yes 2 □N		of Location	Ctmat a	and Alumbas as C	Rural Route Number.
or At ther of	E	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	<i>fy)</i>	treet, ract	огу, опісе		20		Town, Sta		turar Houte Number,
pital Durs a Braf (29a. Certifier 1X Certifying Phy	ysician: To the best of my kn	owiedne den	ith occurr	ed at the tim	ne date and	place ar	nd due to	the cause/	s) and manner of	as stated
Division of To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: Atter this completely filled in by the funeral d	Medical		iner: On the basis of examination and manner stated.									
o the o the omple	Me	29b. Signature and where of certifier			2	9c. Licens	e number			29d. D	ate signed (Mor	oth, Day, Year)
F 5 F 0	1	1/1.62				13	835	3		1	05/14	100
		30. Name and address of person who of	completed cause of death (Ite	m 23a) (Type	, Print)			<u> </u>			-/ /	
10+1 DX		BENE 1. DESMAR	ais mo loc	E. CA.	RNOL	16	t. 5	Alist	bury	ma	. 2180	/
	ate	31. Date filed (Month. Day, Year)	32. Registrar's Sign	ature	1	· .		-	-			
Regis	rar	IIIWI T D 7	2005	15 1	FOR AL							

December Name Private Modified (see) Dece				for State Registrar	State of Ivia	Cei	rtificate of			Reg. No.	JUb	100	391
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Source S				4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County	y of Death		
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The composition of the control of				4.7%					8. Date of Birtl (Month, Day	h y, <i>Year)</i> 1000	9. Birthpl Coun	ace (Stete or 'ry)	Foreign
The part of the		Director		5//-28-0/98		82 113.			Sept. 2	./, 1923	wasn	ingtor	ı, DC
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State Registrar 31. Date filed (Month, Day, Year)

MAY 15 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year McCarthy May 10:35 p M Margaret 10, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring

| House | Spring | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Standard | Sunrise Assisted Living Montgomery 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🕱 F 577-92-0225 87 Yrs Washington, Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If Item 27 is marked other then "natural", or Items 23a or 28e-f show shiply or other traumatic event, the Medical Examinating the notified at sonce. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Tyes 2 ANO Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 14801 Pennfield Circle, #301 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Joseph McCarthy Catherine Elizabeth Quigley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1613 Guston Court, Silver Spring, Maryland 20906 Bernard Bethke/ Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State № Burial 2 Cremation 3 Removal from State May 2006 16, 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Service/Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Stroke 4 Months /Medical Due to (or as a consequence of) Examiner Atrial Fibrillation 4 Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner The law requires that the death certificate be executed been signed by the ettending physicien and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) ☐ Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 3 No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? certificete has 1 Yes 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: within 24 hours after death.

Ve the Funeral Director: After this certifice completely filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Assisted ٩ 1 Yes 2K No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Livina 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43202 May 11, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 3305 N. Leisure World Blvd, Silver Spring, MD 20906 Ozanne-Blankfard, 31. Date filed (Month, Day, Year) egistrar's Signature State 2006 Registrar

		1 - For State Registrar	State of Marylan	d / Depa		Health ar	nd Men	tal Hygi	ene g. No.	06	5 (393
Physic /Medi Examil	cal	1. Decedent's Name (First, Middle, Last) Filadelfo 4a. Facility Name (If not institution, give s	treet and number)	Marin		4b. City, Town, or Location of Death		Date of Death Month May 7	Day 2006 4c. County		(234 W	
Funeral Director		5. Social Security Number 213-61-6816 6. Sex 15 Way 18 Security Number 213-61-6816 15 Way 18 Security Number 15 Security Number 213-61-6816 15 Security Number 213-6816 15 Security Number 213-61-6816 15 Security Number 213-6816 15 Securi	7. Age (In yrs. 52	last birthday) Yrs.	If Under 1 Year Months Days			Date of Birth Month Day 0 / 0 2 /	1953	9. Birthp EG	lace (State o	r Foreign idor
e Maryland Be-1 show	Director	MD Montgomery Gaithersburg							10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country?			
with th	Il Dire	10e. Street and Number 10f. Zip Code 20877						10	ig. Citizen of V El S			
In and Mental by filed within 72 hours after death with the Maryland in and Mental Hygiene. 27 is marked other then "natural" or itams 23s or 28e-f show treumstic event, Ira Madicul Examiner must be published at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 【★ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Spei If Yes, specify Cuban, Mexican, Puerto F 1 X Yes, 2 No. Specify: El Salvador				Specify	14. Race - American Indian, Black, White, etc. Specify: White		
	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) Dishwasher						Resta			usiness/Industry	
	To Be	17. Father's Name (First, Middle, Last) Martin Villanueva 18. Mother's Name (First, Middle, Maiden Sumame) Felicita Marin										
s 1 and 2 should f Health and Mer item 27 is marks other treumatic		19a. Informant's Name/Relationship (Ty) Delores Romero (20a. Method of Disposition	de Marin/	38	ng Address (Stree Dalaman District (Name of	Stre		Gai	thersh	ourg	,Md.2	087
permit. Pages 1 and 2. Department of Health a Importent: if item 27 is eny injury or other tree once.		1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cem. de Santa Ana 5/20						Date 20c. Location · City or Town, State Matapan Santa / 06 El Salvador I FUNERAL SERVICE, P.			dor	
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The law requires that the death certificate be executed with the law requires that the death certificate be executed as the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1										
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sician: The law requires t certificate has been signe rector, page 2 should be o	Completed						_	perform	autopsy prior to completion of car performed? death?			available ause of
To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, page	atlon: To Be	27. Manner of Death 1 Death 2 Death 2 Death 1 Death 1 Death 2 Accident investigation										
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	Medical		he time, date and place, and due to the cause my opinion, death occurred at the time, date a									
To t To t	×	29b. Signature and title of certifier	We		29c. License number			29d. Date signed (Month, Day, Y			Day, Year)	
,		30. Name and address of person who co	ompleted cause of death (Iter	n 23a) (Type,	PIGE, POX	Kjus, m	0 16821					
St Regis	ate	31. Date filed (Month, Day, Year) MAY 15 2	32. Registrar's Signa	ature	poels							

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Reg. No. 16894
	Physicia /Medic	al .	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 8: UDAM 8: UDAM 1. Decedent's Name (First, Middle, Last)
	Examin Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Country of Death Cec. Country of Deat
	Maryland e-f ehow iffed at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10c. City, Town or Location 10d. Inside City Limits 10c. City Town or Location 10d. Inside City Limits
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Ptyglene. Important: If Item 27 ie marked other than "natural", or Iteme 23a or 28e-f show eny injury or other traumatic event, Ite Medical Examinations must be notified at once.	by Funeral Director	106. Street and Number 3
21215-0036	filed within 72 hou Hygiene. other than "nature ant, the Mark Call	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)
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Balti	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Liversee 22. Name and Address of Facility Bennie Smith Funeral Home P. D. Bax 331 Polomotics City, md, 2189
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Disease are condition.
0,	Examiner sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Underlying C. Universal by Section Underlying C. Universal by Section Underlying C. Due to (or as a consequence of):
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P.O. Box	The law requires that the death certificate te has been signed by the atlanding physoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
	quires that n signed b		Post II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 239. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records,	icien: The law requir certilicate has been si rector, page 2 should I	Completed by	DICINETES MELLI TUS 24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
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ision	Attending Physicien: r death. ector: Alter this certific by the funeral director.	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined elemined. 28a. Date of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred
Οį	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely tilled in by the		4 Homicide determined building, etc. (Specify) 29a. Certiflier 1/1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hos within 24 hc To the Fun completely	Medicai	(Check only a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of the signature and title of the cause (s) and manner stated.
	T wit		J ////////////////////////////////////
B.	A 5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John R. Mulvey M.D. III West High Street, Elkton Md. 2/921
	Sta Regist		31. Date filed (Month, Day, Year) /32. Begistrar's Signature MAY 1 5 2006

DHMH 17 Rev 1/2001

Amend #6 per FD 5-12-06 A.A.Co.Health Dept.PM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) May 10, Year **Physician** 2006 10:00 P M Edgar Mason /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Edgewater Anne Arundel South River Health & Rehab

5. Social Security Number 6. Sex 7. Age (In yrs. last binthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Dey, Year) 09/26/1946 Birthplace (State or Foreign Country) **Funeral** Days 1**5**₩ 2□ F 59 Yrs. Michigan 214-46-1921 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or than "natural", or Items 23a or 28a-f show the Medical Examiner; sust be notified at 1⊠Yes 2□No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2610 Greenbriar Lane 21401 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 196 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1966-1 Never Married 2 Married 1 ☐ Yes XX No Specify: Specify: White 69 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Rehab & Addiction Elementary/Secondary (0-12) College (1-4or 5+) Manager 9 Facility 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. James Jacob Blanche Williams Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances R. Davis - Daughter 334 West Oakdale St., Mt. Airy, NC 27030 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory May 12, 2006 Edgewater, Maryland 22. Name and Address of Facility 21. Signature of Funeral Septide Lipépsee George P. Kalas Funeral Home, P.A. 2973 Solomons Island Rd., Edgewater, MD 21037 cas 23a. Part. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) orgestive Priysician /Medical Warrany Discourse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Iclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide **Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

physician and s the burial-transit that the death certificate be executed Box 68760, use jo P.0. the a Division of Vital Records, page 2 should be After this certificate has or Attending Physician: death. within 24 hours after death To the Funeral Director: completely filled in by the To the Hospital

with the Maryland

filed within 72 hours after death

and Mental Hygiene.

Maryland 21215-0036

29a. Certifier Medical (Check only one) 29b. Signature and five of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

NTUL DRVE 827 LINDE

BAUTIMORE LINDEN AVE

State Registrar

31. Date filed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. -2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Physician Year MARY APPOLE NIA

4a. Facility Name (If not institution, give street and number) 1410 NOYES MA 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner RININSULA Wicom Ico REGIONOR If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Quantry) **Funeral** 1□M 2KF Days Hours 220-38-8936 MD Director Usual Residence of Dec 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ehov the Medical Examiner must be notified at 1 XYes 2 ☐ No Funeral Director WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2180 5522 WOD BINE LANE. larital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 KNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify WHITE 1 ☐ Yes 2 No Specify: ۾ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) -KOME MAKER UWNED HOME or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ages 1 and 2 should be fill nt of Heelth and Mental H t: If Item 27 is marked oth Be CHARLES WILLIAM WALTER ATHERINE SOSEPHINE WE'SS MARY FUZABETH HUGES DROUNTER 53 AVAIDS N
20b. Place of Disposition (Name of cemetery, crematory or other place) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ace of Disposition (Name of Date 20c. Location - City or Town, State Baltimore, permit. Pages 1
Department of H
Important: If Itel
sny injury or ott 4 □ Donation 5 □ Other (Specify) SAUSKURY CHEMPTICAL 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21. Signature of Funeral Service Licensee PO BOX 61 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Prumoma Respirenting failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 ☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 No 1 🗌 Yes 3 Probably 4 Unknown 24a Was an

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. death

220-38.

Be Completed Certification: To

Director: After this certific in by the funeral director, within 24 hours after To the Funeral Dire

State Registrar

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

↑ Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

SOUTH 31. Date filed (Month, Day, Year) MAY 1 7 2006

moun North

DIVISION ST, SAUSBURY, 32. Registrar's Signature

DR. USHA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



0057359

May 10/ 2006

NATESAN

State of Maryland / Department of Health and Mental Hygiene 2 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ELTRAY NUTTER 2006 7 au /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner legional medical Center If Under 1 Year I If Under 24 Hrs. WICOMICO 8. Date of Birth (Month, Day, Year) AUG 9 1919 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF Days Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examinat must be notified at 1 Yes 2 No Funeral Director MD BIVALVE WICOMICO 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21005 OLD SCHOOL ST. 21814 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. e filed within 72 hours after all Hygiene.
other than "neturel", or Itel 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SEAFCOD SEAFOOLD PACCESSING permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy important: If item 27 is marked other eny injury or other traumatic event, sonce. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ROBERT NUTTER WILLOW BARCLAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HESTER JOHNSON 3668 TEXIAS RD BIVALVE MD 31814
20 of Disposition (Name of 200. 1 SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BIVALVE, MID ELSEY CHUTCH CEMETERY 5-20-06 22 Name and Address of Facility
MESSICK FUNERAL HOME
BIVALVE MD 21814 21. Signature of Funeral Service Licensee PO BOX 61 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** neumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown aremia been: diabetes 24b. Were autopsy findings available prior to completion of cause of death? this certificete hes autopsy performed: 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1.XNatural 5 Pending s efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 120853 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peninsula Regional Medical Center, Salishary mo B. SILVER JV NO

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

			1 = For State RegistrayFND#23c-27+29	State of MaperMD5/16/								Reg. No	7 11 11	16	168	398
	Physic	an	Decedent's Name (First, Middle, La.	st)							2. Date of I	Day	,	Year	3. Time of	
	/Medi Examir		LAWRENCE GORDON 4a. Facility Name (If not institution, giv. MONTGOMERY GENERAL H		r)			Town, or	Location o	of Death	MAY 8,	4c.	County of	f Death	8:56	A M
1	Funeral Director		27. 30 0333	ex 7. A	ige (In yrs. las 60	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of E	Sinth Day, Year)		9. Birthpla 1ARYLA	ce (State o	r Foreign
	Maryland 1-1 ehow	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND MONTGOME	RY	10c. City, SILV	Town or Lo								100	d. Inside Ci	
	with the 3a or 28	I Director	10e. Street and Number 1805 ARMOND LANE				10f. Zip	Code 0905					izen of Wh	nat Country	y?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show amportant: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examinar must be published.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 H If Yes, Give Year or Dates	?] No		Was Deced If Yes, spec			gin? (Spo n, Puerto	ecify Yes or N Rican, etc.)	No-	14. Race Black, Specify:	American White, etc	c.	
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Maryland 21215-0036	ild be filed v fental Hygie rked other t lic event, ID	To Be Co	17. Father's Name (First, Middle, Last) GORDON GILHAM NOBL			INSU	IRANCE	EXECU	18. Mothe		FAYE GOR	le, Maiden	F-EMPI Sumame)			
, Mary	and 2 shoulaith and No. 27 is mail		19a. Informant's Name/Relationship (SHARON NOBLE - WIFE	Type, Print)					and Numbe	er or Rura	al Route Num	ber, City o	r Town, Si	tate, Zip C	ode)	
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	ledical	one) 2 Medical Exam	ysician: To the bes niner: On the basis and manner s	of examination	edge, death n and/or inv	vestigation,	in my op	inion, deat	d place, a	and due to the ed at the time	e cause(s) , date and	and mann place, and	er as state d due to th	ed. e cause(s)	
)	2 500	Σ	29b. Signature and title of dentifier	Un).	0		H	DO	613	16		29d. Date	signed (I	Month, Day 200	y, Year)	
			30. N e and address of person who a		death (Item 23 IGOMERY (,	TAL	OLNE	EY. MI	D 20850	- /				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 6 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Sidney 05 1500 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury A00 ake Wicomico | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, VAPTIL 8) 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign Country) 1926 Maryland 6. Sex **Funeral** 1 X M 2 □ F 80 218-20-6553 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4438 Nutters Cross Road 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1945— 1 XYes 2 ☐ No It Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 naturel', or 1 ☐ Yes 2 🛣 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Yard Foreman Lumber Yard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willis Francis Pusev Ruth Perdue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise S. Pusey/Wife 4438 Nutters Cross Road, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Pages
Department of |
important: if its
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 XOther (Specify) Entombment Wicomico Mem. Park 5/16/2006 Salisbury, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zeller Funeral Home, PROSALISBUTY, Maryland 21802 Part. Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one sense on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien end for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, ourcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ecropic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did fobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificete has l irector, page 2 s autopsy лтед?. 2 **2 N**o 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural ≥ □ Accident 5 Pending death. 1 □ Yes 2 □ No investigation 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, efc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 29c. License number 29b. Signature and title of certifie 0005 3410 Zu 30. Name and address of person who completed cause of death (Îtem 23a) (Type, Print) SALISBURY HULAM 26266 WARIS ARROWWOOD CT. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 7 2006 Registra

			1 - For State Registrar	State of Maryla				leaith and <i>Death</i>	Mental H	ygier Reg. 1	ZUU	6	16900
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		36	Calvert Memorial	Hospital	face birth day	Pr	ince	Frederi			Calver	ct C	ounty
	Funeral Director		5. Social Security Number 6. S 217–64–9432	5ex 7. Age (In yrs	. last birthday) Yrs.	Months		Hours Mi	n. (Month,	Day, Yea			ce (State or Foreign
A 6			Usual Residence of Decedent	00					Dec.	9, 1	.952 W	asnı	ngton, DC
	nylan how	_	10a. State 10b. County	10c. C	ity, Town or Lo	cation						100	d. Inside City Limits
	Ba-f	cto	MD Calvert	Co.	Dunkir	k				.,.			1 ☐ Yes 2 X No
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o	Attending Physician: or death. ector: After this certification in the funeral director.	Η,	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		28c. Injun Work	4 □ Nursing at	Home 5 ☐ Re			Specify)	
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	To the within 2 To the complet	Me	29b. Signature and title of certifier	7 -		29	c. License	number		29d. D	ate signed (M	onth, Da	y. Year)
			Den /	Tale NO			04	7610		7	May 15,	200	06
	n		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)							
	10		David J. Tardio	, M.D. 14090	Solomor	s Is	land	Road,	Solomons	, Ma	ryland	206	88
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	7 2006 Registrar Sign	ature	1							
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	Physici	on	1. Decedent's Name (First, Middle, Last,)				2. Date of De		Year	3. Time of Death
	/Medi		Emile Rutne	r				May	Day,	2006	11:40 Am
	Examir	ner	4a. Facility Name (If not institution, give	·			m, or Location of Dea	th		inty of Death	
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	Funeral Director		5. Social Security Number 6. Security Number 200-09-5648	x 7. Age	(In yrs. last birthday) 85 Yrs.	If Under 1 You Months Da	ear If Under 24 Hr. ays Hours Min		28 ^{Y gar)} 192		lace (State or Foreign try) 1gary
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	3a or 3	Dir	10e. Street and Number 1801 E. Jefferson	Street, #	231	10f. Zip Coo 2085			-	of What Coun	try?
	ms 2	Jera	11. Maritaf Status	12. Was Decedent Ev	ver in U.S. 13.	Was Decedent	of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No	- 14. F	Race - America	
38	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heetih and Mental Hygiene. Department of Heetih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show emportant: If Item 27 is marked other than "natural", or Items 23s or 28s-f show envisionately injury or other treumatic event. The Medical Examinar must be positived at once.	by Funeral Director	1 X Never Married 2 Married 3 Widowed 4 Divorced	Agned Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:	A 20037	If Yes, specify 0 1 ☐ Yes 2【【】		rto Rican, etc.)	Spe	Black, White, e	S. A.
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Oc kind of work do	ccupation one during most of wo stired)	orking	16b. Kind of	f Business/Ind	lustry
121	within ene. than	ompi	Elementary/Secondary (0-12)	Colfege (1-4or 5+	}	DO NOT use re ientist	itired)		U.S.	Gover	nment
d 2	filed Hygi other	ပိ	17. Father's Name (First, Middle, Last)	<u>J</u> T	50.	Lencisc	18. Mother's Na	me (First, Middle,			
an	id be lental ked ic ev	To Be	Adolph Rutner				Mo11	y Kassir	er		
Maryland	shou and M is mar	-	19a. Informant's Name/Relationship (Ty	rpe, Print)			reet and Number or F				
ĕ,	and 27 in 27 in 18 cm		Helen R. MacKenzie	e - Sister			e Avenue,	Bethesda			20814
Baltimore,	Pages nent of h ant: If its		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		20b. Place of Dispo cometery, crer Garden of		brance 5-4			on - City or Too Sburg,	wn, State Maryland
Balt	permit. Departimporta eny inj		21. Signature of Funeral Service Licens	Dotte			dress of Facility agel Funer kyille Pil				nd 20852
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the cause on each line		er the mode of	dying, such as cardia	c or respiratory ar	rest,	Maryla	Approximate Interval Between Onset and Death
		Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	Endstage Consequence of): Pneumonia consequence of):	Renal D	isease				
68760,	ficate be physici s the bu	edicai		1.							
P.O. Box	The law requires that the death certificate be executed sie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	Ectopic pregna Other (specify				Date of deliver Month [ry Day Year
ds, P	uires that signed t d be det	ρχ	Part II. Other significant conditions con	ntributing to death but	not resulting in the ur	nderlying cause	given in Part I.		es 2 🗓 No		e cause of death?
Records,	aw requir is been si 2 should	Completed						24a. Was	an 24	b. Were autop	sy findings available
Ž.	The lav	E						autop perfor 1 ☐ Yes	med?	prior to com death? 1 🔲 Yes 2	pletion of cause of
Vital	iician: Th certificete rector, pag	Be	25. Was case referred to medical				26. Place of De	ath Check only or	1000	, , , , , ,	110
>	ω (1)	2	examiner? 1 ☐ Yes 21☑ No	lospitaf: 1X fnpatient	2 ER/Outpatien	t 3 DOA	Other: 4 🗌 Nursing I			Other (Specify))
	After fune		27. Manner of Death 1 ☑ Naturaf 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day)	28b. Time of Injury	28c. le	njury at Work? I _ Yes 2 _ No	28d. Describe h			
Division	i Dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	r - At home, farm, stre (Specify)	eet, factory, offi	се	28f. Location (S City or Tow	itreet and Nui n, State)	mber or Rural	Route Number,
	To the Hospital or At within 24 hours after C To the Funeral Directompletely filled in by	Medical C	29a. Certifier (Check only one) 2 Medical Exemin	sicien: To the best of ner: On the basis of e and manner state	xamination and/or inv	n occurred at the restigation, in m	e time, date and place by opinion, death occ	e, and due to the durred at the time, d	ause(s) and late and place	manner as sta e, and due to	ited. the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date sign	ned (Month, D	lay, Year)
	10) pres	let-el Ja	yonti.		D0052586		May l	1, 2006	
	(0		30. Name and address of person who co			,		1	_		1 0-01-
	-		Dr. Jayant:	i Lalbhai 32. Registrar		OUU For	est Glen R	toad, Sil	ver Sp	ring,	md. 20910
	Sta	-	MAY 15	2006 No. 1	S SIGNATURE	Joseph .					

			State of Maryland 1 - State of Maryland 2 - State of Maryland 1 -	-	artment of F		ental Hygie	2000	16903
	Dhuaisi		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medi		Lilly Roeber			M	ay 11	2006	1:40 P M
	Examir	ier	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	th
Z		. 2	Montgomery General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last	hinteda . N	01ney	If Under 24 Hrs.	0.00.00.00	Montgome	
	Funeral Director		50€ 40 0€00 1 M 2₩ F	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Bir	thplace (State or Foreign ountry)
1			536-40-8633 78 Usual Residence of Decedent				Sep.7, 19	2/ Ger	many
	how		10a. State 10b. County 10c. City, To	own or Lo	cation				10d. Inside City Limits
	Sa-1 s	cto	Maryland Montgomery Ro	ockvi	11e				1 ☐ Yes 2 ☐ No
	ith th	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?
	s 236		13105 Dumbarton Drive	140.1	208			USA	
	Item Item	Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	13. 1	Yas Decedent of F Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto P	ity Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
936	urs af	by	3 ☒ Widowed 4 ☐ Divorced Year or Dates:		☐ Yes 2☑ No	Specify:		Specify:	71
21215-0036	d within 72 hours after death with the Maryland Jiene. r than "natural", or liems 23a or 28a-1 show I'ra Madical Exa ninst frout Le rodified at	Completed	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occup		16b	. Kind of Business	Thite Industry
21	within 7 ene. than *r	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired	during most of working d)	g		
2	filed within Hygiene. other than			Techn	ician			eterinari	an
ng	2 m 2	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid	fen Sumame)	
ž	should be ind Mental marked c	2	Joseph Sperling 19a. Informant's Name/Relationship (Type, Print) 1	Ob Mailie	= Address (Street		izabeth l		7-0-41
Maryland	01 (0 ==					and Number or Rural			
	Health Tem 27		20a. Method of Disposition 20b. Place	of Dispo	sition (Name of	on Drive		Location · City or	
Ö	Pages nent of int: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metro 4 ☐ Donation 5 ☐ Other (Specify)	opoli	tan	1			
Baltimore,			21. Signature of Funeral Service Licensee	22	rematory Name and Addre	ss of Facility			,Virginia
Ä	permit. Departr Importa any inje		Willia J BN	Fr	ancis J. O Univer	Collins F sity Blvd.	uneral Ho	ome, Inc.	MD 20901
			23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not ente	er the mode of dying	ng, such as cardiac or	respiratory arrest,	oping	Approximate Interval Between
	Physician				PRET				Onset and Death
20	/Medical		resulting in death) Due to (or as a consequence	ce of):	111231	4			MINUES
€.	Examiner		Immediate Cause (Final disease or condition resulting in death) a. CARD IAC Due to (or as a consequence of the conditions) Sequentially list conditions.	PDIA	L IN/	ARCTION			
À	D iii	iner	if any, leading to immediate Due to (or as a consequent cause. Enter Underlying Cause) (Disease or injury	ce of):					
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	an of):					
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		Due to (or as a consequent	CB OI).					
687	phys phys s the	edicai	d		-,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
Box (eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					23d. Date of del	n on c
ă	death a atter	clar	in the past 12 months? 1 Yes 2 No 1 Yes 2 No		Ectopic pregnancy Other (specify)	·		Month	Day Year
P.O.	at the de by the tached	Physician/M	9 Unknown 9 Unknown						
	res tha signed b	by P	Part II. Other significant conditions contributing to death but not resulting	g in the un	derlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Vital Records,	w require been sig should b						1 Tes	2 No 3 Pr	obably 4 Onknown
သို့	e law requ has been je 2 shoul	ompleted					24a. Was an autopsy	24b. Were au	topsy findings available
Ĕ.	The ate h	Сош					performed	death?	completion of cause of 2⊡ No
/ita	eician: certifica irector, p	Be (25. Was case referred to medical examiner?			26. Place of Death			
of\	Attending Phyeician: r death. ector: After this certifici by the funeral director.	ဥ	1 ☑Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☑ ER/	Outpatien		4 Nursing Hollin	e 5 🗆 Residence	6 ☐Other (Spec	oify)
Ž.	ding P. h. After funera	ion:	1 ☑ Matural 5 ☐ Pending (Month, Day Year)	b. Time of Injury	28c. Injun Worl	k?	d. Describe how in	jury occurred	
islo	Attender death	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home,	form etre		Yes 2 □ No	If Location (Street	and them has as O	
Division	after Direction by	ertification:	4 Homicide determined 286. Place of Injury - At nome, building, etc. (Specify)	, iaiii, sue	et, ractory, onice	20	f. Location (Street City or Town, St		rai Houte Number,
	To the Hospitel or Attentwithin 24 hours after deatle to the Funeral Director: gompletely filled in by the	O	29a. Certifier 162 Certifying Physician: To the best of my knowled	dge, death	occurred at the tin	ne, date and place, an	d due to the cause	(s) and manner as	stated
	P Ho	edical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or inv	estigation, in my o	pinion, death occurred	at the time, date a	ind place, and due	to the cause(s)
	To the within 2 To the gomple	Me	29b. Signature and title of certifier		29c. License		29 d M	Date signed (Month	200 Fear)
	26		& Lorhinmo		D	19815	may	12 20	76
	ر ا		30. Name and address of person who completed cause of death (Item 23a	a) (Type, F	Print)	18	101 PRIN	JCE PHIL	LIP DRIVE
			K. LARKIN, M.D. MONTGOMER	y 6E	N. HOST	E.R.	OLNEY,	mD 2	1832
	Sta Registr	-	30. Name and address of person who completed cause of death (Item 23a) R. LARKIN M.D. MONTGOMER 31. Date filed (Month, Day, Year) MAY 15 2006 32. Pegistrar's Signature	A.	and in		,		

Physician /Medical Examiner	1. Decedent's Name (First, Middle,	Lastl						Reg. No.		1 / 1	001
	Beatrice Ro	oberts			• ·		2. Date of De Month May 1		Year	3. Time 6	Death A
150	4a. Facility Name (If not institution, 13222 Pine Road		r)	4b. City,	Town, or Local	ion of Death		4c. County		orges	
Funeral Director	577-18-0884	5. Sex 7. A 1 ☐ M 2 ☐ X F	Age (In yrs. last birth) 87 Yr	Months	T 1 Year If Ur Days Hou	nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da Feb. 2	th Year)		olace (State	
fed at	Usual Residence of Decedent	Georges	10c. City, Town o				<u> </u>		1	10d. Inside 0	
the notified	10e. Street and Number 13222 Pine Road	1		10f. Zip	Code 20720			10g. Citizen of	What Cour	ntry?	
nd other then "neturel", or Iteme 23e or 28e-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 🖫 Widowed 4 Divorced	12. Was Deceder Armed Forces	? [No	13. Was Deced	dent of Hispanic city Cuban, Mex	cican, Puerto	ecify Yes or No Rican, etc.)		ck, White,	can Indian, etc. ite	
t, the Medical I	15. Decedent's (Specify only highest Elementary/Secondary (0·12)		r 5+)	ecedeni's Usua Bive kind of wo fe. DO NOT us memaker	rk done during se retired)	most of work	ng	16b. Kind of B		dustry	
	17. Father's Name (First, Middle, La George Benjamir		, 210	monique.			(First, Middle,	, Maiden Suman			
mag and	19a. Informant's Name/Relationship Carol Thompson/	(Type, Print)				imber or Rura	al Route Numbe	er, City or Town,	State, Zip	Code)	
2 = 5	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐Removal from State	20b. Place of D	isposition (Nari crematory or o	ther place)	1 0	ie, MD (2006	20720 20c. Location - Waldon	•		
important; eny injury once.	21. Signature of Funeral Service Lie			22. Name an	od Address of F	acility Rob	pert E.	Evans l wie, MD		al Hom	ne
ial-transit mand instruction in and instruction in a contract in a contr	23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tany, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Dem course on each pue to (or a b. Due to (or a c.	entto s a consequence of)	alzh	e im e c	_	r respiratory a	rrest,		Approxima Interval Be Onset and	tween Death
igned by the attending physicis be detached for use as the bur by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition: Outoinmuse Prior	d	2 Fetal death at time of death but not resulting in the	3 Ectopic pr 5 Other (sp	ause given in P			Dbacco use cont	ribute to th	Day	
page 2	prior	to death		-	<u> </u>			rmed?	prior to cor death?	osy findings npletion of o	availab ause o
director, p	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	tient 2 ☐ ER/Outpa	itient 3 DO	Other		Check only o	ne) dence 6 □Oth	ar (Snecih	4)	
Atter th uneral	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	28a. Date of In (Month, D	jury 28b. Tim		8c. Injury at Work?	2		now injury occurr		7	
To the Funeral Director: completely filled in by the f Medical Certificat	4 Homicide determine	building, e	njury - At home, farm etc. (Specify)				City or Tow		_		iber,
To the Fun completely Medica	(Check only 2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	of examination and/o	r investigation,	in my opinion,	death occurre	ad at the time,	date and place, a	nner as st and due to	ated. the cause(s	;)
woo W	29b. Signature and title of certifier Marcy D 30. Name and address of person wh Nancy D · Rive 31. Date filed Month, Day, Year)	Ri-Ka	igmp.		License numb		ruland	29d. Date signed	(Month, L	Day, Year)	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5 William Grason Richardson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Chesi 5/19 If Under 24 H If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Year) 1**X**M 2□ F 214-32-0998 71 Yrs Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or items 23s or 28s-f show the Medical Examiner must be notified at Dorchester MD Cambridge 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3109 Steamer Run Road 21613 USA filed within 72 hours after deeth v Hygiene. xther then "netural", or ttems 23s Funeral 12, Was Decedent Ever in U.S. Ammed Forces? 1 g(Yes 2 □ No If Yes, Give Year or Dates: 1952–55 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Slatus 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: white δ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) game warden federal government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked oth any njury or other traumatic event once. William H. Richardson Edith Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri Willis daughter 5434 Cannon Road, Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 5/17/06 Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. Brick. Bur 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypotension house /Medical Due to (or as a consequence of): Examiner Acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last renal Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at lime of death 5 Other (specify) signed by the a id be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? Pulmonary 24a. Was an Clostridia this certificete has at director, page 2 autoosy performed? Preumonia 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Minpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Dire 4 | Homicide within 24 hours a To the Funeral (Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50804 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 408 O.M. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 6 2006 Registrar

			State of Maryland / Den	partment of Health and Me	-	
			101	ertificate of Death	Reg. I	2006 16906
П			Decedent's Name (First, Middle, Last)		. Date of Death	3. Time of Death
	Physici /Medio		WILBERT LEON SISCO, SR.		MAY 23	2006 10:10a ^M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Chester River Hospital Center	Chestertown i) If Under 1 Year If Under 24 Hrs. 8		Kent
	Funeral Director		5. Social Security Number 218-20-1874 Usual Residence of Decedent	Months Days Hours Min.	Date of Birth (Month, Day, Yea 'eb 23]	9. Birthplace (State or Foreign Country) Maryland
	yland		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	en-1 st	ctor	MD Kent Cheste	rtown		1 ☐ Yes 2 🛣 No
	within 72 hours after death with the Maryland jene. r then "natural", or Items 23a or 28a-f show the Medical Evantret must be notified at	Funeral Director	10e. Street and Number 8221 Tolchester #11	10f. Zip Code 21620		Citizen of What Country?
9	after dea or Items rurer m	Funer	1 ☐ Never Married 2 ☐ Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Rid	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	nours a	d by	3 ☐ Widowed 4 X Divorced Year or Dates: -1947	1 ☐ Yes 2√2 No Specify:		Specify: Black
15-("natu	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)		Kind of Business/Industry
212	within iene. rthan "	ошр	Elementary/Secondary (0-12) College (1-40r 5+)	lice Officer	()	ty Police
b	Hyg Hyg ent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (#	First, Middle, Maide	partment en Sumame)
Maryland	ould be Mental arked c	ToE	Leon Sisco	Helen B	lack	
lan	s 1 and 2 should f Health and Men Itam 27 Is marke other traumatic			ing Address (Street and Number or Rural F		
	fand fealth im 27 ther ti			1 Tolchester #11 osition (Name of Date		ertown, MD. 21620
Ž	Pages nent of H int: If Its try or of			nmatory or other place)		Location - City or Town, State
Baltimore,	# 문변분 .			remation 5/24,		yrna, DE.
Ba	permi Depa Impo any ii		M00510 1.	18 West Cross St	• Galen	tephen L. Schaech a, MD. 21635
В			23). Part1. Exter the disease, or complications that caused the death. Do not en shock, or healt failure. List only one cause on each line. Immediate Cause (Final	iter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical	i II	disease or condition resulting in death)	modern	_	3 045
ľ	Examiner		Due to (or as a consequence of):	trutive. 7 lm	ey D	were Bules
0	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	10000		5-7450
Di	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or 45 aconsequence of):	ue Herond	101	we so
760,	ate be executed hysician and the burial-transit	cai E	Due to (or as a consequence of):			0 ,
687	ficate physis the		d			
Вох	death certifica e attending ph id for use as th	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	75.		23d. Date of delivery
o.	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med		□Ectopic pregnancy □ Other (specify)		Month Day Year
S,	The law requires that the tee has been signed by th bage 2 should be detache	by PI	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Records,	equire				1 🗌 Yes	2 □ No 3 □ Probably 4 ▼Unknown
eco	law r nas be e 2 sh	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E H		Con			performed? 1 ☐ Yes 2 🔀 N	death? o 1 Yes 2 No
Vital	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (C		
of	tding Physician: th. : After this certifica s funeral director,	T. To	27. Manner of Death 28a. Date of Injury 28b. Time o	of 28c. Injury at 28c	5 Residence I. Describe how inj	6 ☐ Other (Specify)
ion	Attending r death. actor: After by the fune	atior	1 Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		,
Division	or Atte after de: Diracto in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office 28f.	Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
_	To the Hospital or Attenc within 24 hours after death To the Funaral Diractor; completely filled in by the	Medical Co	29a. Certifier (Check only 29a. Medical Examiner: On the best of my knowledge, deat 2□ Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place, and executivestigation, in my opinion, death occurred	due to the cause(s) and manner as stated.
	thin 2 thin 2 o the	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
	⊢≥≓ŏ			00061321		24.06
	143		30. Name and address of person who completed cause of death (Item 23a) (Type,			
_	31		Semra Sahinci, MD 420 Pennsy	lvania Ave. Cent	reville	, MD. 21617
	Sta Registr	_	31. Date filed (Month, Day, Year) MAY 3 0 2006 2. Registrar's Signature			
			INTI O O COOO ACCURACIONAL			

			Tor State of Maryland / Department State of Maryland / Department Certifica	nt of Health and te of Death		Z 11 11 is	16907
	o		Decedent's Name (First, Middle, Last)	or Boain	2. Date of Death	. No 0 0	3. Time of Death
	Physici /Medic		LOLA BOWEN SCRIVENER		MAY 20,	2006 Year	5:45 PM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City	, Town, or Location of Dea		4c. County of Death	
			8530 WEDDING DRIVE WE	ELCOME		CHARLES	
	Funeral		1 M MYF	r 1 Year If Under 24 Hrs Days Hours Min		ear) 9. Birthp	place (State or Foreign
	Director		216-46-8885 1 96 Yrs.		AUG. 8, 1	909 MAR	YLAND
	iand ow		10a. State 10b. County 10c. City, Town or Location			1	Od. Inside City Limits
	Many	tor	MARYLAND CHARLES WELCOME				1 ☐ Yes 2 📉 No
	or 28g	Director		p Code	10g	. Citizen of What Coul	ntry?
	23a c	ain	8530 WEDDING DRIVE	20693		U.S.A.	
	tams ter m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent	dent of Hispanic Origin? (S crify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
36	or It	by Fı	1 Never Married 2 Married 1 Yes 2 No			Specify:	
ô	filed within 72 hours after death with the Maryland Hyglene. thar than "natural", or Itams 23a or 28a-f show thar than "natural", or Itams 23a or 28a-f show ant, the Modical Examinar must be notified at	ed b	3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usi	al Occupation	161	b. Kind of Business/In	HITE
21215-0036	n "na	Completed	(Specify only highest grade completed) (Give kind of w	ork done during most of wo	rking	b. Airid of Dusinessan	uusiiy
212	ad with)om	Elementary/Secondary (0-12) College (1-4or 5+) 1 2 HOMEMAKE	:R		OWN HOME	
9	be file ital Hy id oths avant,	Be	17. Father's Name (First, Middle, Last)		me (First, Middle, Mai		
Maryland	2 should be and Mental is marked or reumatic ave	2	AGABUS HENRY BOWEN	SALLY	WILSON		
<u>a</u>	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygtene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic avant, Tre Modical Examiter must be notified at			s (Street and Number or R	ural Route Number, C	ity or Town, State, Zip	Code)
	1 and 2 Health am 27 thar tra		LOLA CARLENE BIAS-DAUGHTER 8530 WE 20a. Method of Disposition (Na	DDING DRIV			
סר	Pages 1 ar nent of Hea int: If itam : iry or othai		1 ☐ Burial 2XXX remation 3 ☐ Removal from State cemetery, crematory or	other place)		c. Location - City or To	wn, State
altimore,			* 4 □ Donation 5 □ Other (Specify) METROPOLITIAN CRE 21. Signature of Fineral Service Licenses MO 7 22. Name a	MATORY 5- nd Address of Facility	22-06 A	LEXANDRI	A, VA
Ba	permit. Departr Importa any inju		Prince & RAYM	OND FUNERA			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mo	LATA, MARY de of dying, such as cardia	LAND 20 c or respiratory arrest,	646	Approximate
	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	THE PL	D'Seat	e.	Interval Between Onset and Death
1	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	101	10		
	Examiner		Sequentially list conditions, b.	~			
7	D is	iner	cause. Enter Underlying Cause (Disease or injury				
γ_n	and and I-tran	Examiner	resulting in death) Last Due to (or as a consequence of):				
8760,	icate be executed physician and s the burial-transit	dical E	4				
687	ificate g phy: as the	0	a.				
Вох	n cert	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ry
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	in the past 12 months? 1 Yes 2 No 1 Yes 2 No 1 Use birth 2 Fetal death 3 Ectopic p 4 Pregnant at time of death 5 Other (s)			Month	Day Year
0	at the	hys	9 ☐ Ouknow₩			4	
	res th ignec	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	ause given in Part I.		co use contribute to th	\
0.00	w require been sig should b	eted			1 Tes	2 No 3 Prob	ably 4 Staknown
Records,	has t ge 2 s	ompleted	1		24a. Was an autopsy performed	24b. Were autor prior to con	osy findings available inpletion of cause of
		O			1 □ Yes 2 □		2 No
Vita		o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 D	04	ath (Check only one)	0.000	
o	4 = E	-	27. Manper of Death 28a. Date of Injury 28b. Time of	28c. Injury at	28d. Describe how in	e 6 □Other (Specify njury occurred)
on	Attanding F death. ctor: After y the funera	atio	→ Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation M	Work? 1 ☐ Yes 2 ☐ No			
Division of	after death Diractor: in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	y, office	28f. Location (Street City or Town, St	t and Number or Rural	Route Number,
	ital or ris aft ral Di	Cer			0.0, 0. 70.0, 0.		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral preserve.	edical	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation	at the time, date and place, in my opinion, death occu	, and due to the cause irred at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Med	and manner stated.	c. License number		Date signed (Month, L	
	2 3 Z 8		Marie Myatt	1225) 230.	Tailed (Morill), I	ruy, (Gai)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1) 00 3 5		, 1-11-0	
	2		Po Bo X 1703 Lap (ofa r	DO6 C-	546	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			-	
	Registr	ar	MAY 3 0 2006 Blocked It special				

State of Maryland / Department of Health and Mental Hygiene 006 16908 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 14, 2006 John Michael Steczak 1425 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Ye Aug. 29, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 PA Funeral Year) 1**X** M 2□ F Months Days Hours Min. Director 171-03-7324 90 Usual Residence of Decedent fited within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Funeral Director Berlin Worcester 10e, Street and Number 10f. Žip Code 10g. Citizen of What Country? 9715 Healthway Dr. 21811 USA 12. Was Decedent Ever in U.S. Agned Forces? 1 ∑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White ō 1 ☐ Yes 2 🛣 No Pages 1 and 2 should be filed within 72 hours at inent of Heatth and Mahetal Hyginene.
ant: If tiem 27 is marked other than "natural; on the treatment or other treatment or other treatments." If Yes, Give Year or Dates: WWII Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Meat and Poultry Inspector State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Paul Steczak Mary Duda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Michael Steczak 419 Union Rd., Ahoskie, NC 27910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Department of importent: If any injury or once. Spring Hill Cemetery May 19, 2006 Girdletree, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home ature of Funeral Service Licensee 108 William St., Berlin, Md. 21811 79a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List enty one cause the each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician. Urinary Tract /Medical to (or as consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit ehydration Due to (or as a consequence of): Be Completed by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Kenal Failure 1 Yes 2 No 3 Probably 4 Unknown Heart Faihure Congestive 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2XI No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Medical Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred fo the Hospitel or Attending Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel L 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 14-1 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) Attending 05/14/2006 ammas (tem 23a) (Type, Pr 30. Name and address of person who completed cause of death Healthway Dr Berly, MD 21811 5+1 Hamnes 31. Date filed (Month, Day, Year) State MAY 1 6 2006 Registrar

7324

03-

Steczak

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 16909 State of Maryland / Department of Health and Mental Hygiene UU 6 Certificate of Death

Physician
/Medical
Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if Items 27 is marked other than "natural", or Items 23s or 28s-1 show eny linity or other traumatic event, if a Medical Exertit at ment be recitified at appare. Baltimore, Maryland 21215-0036

> Physician /Medical Examiner

3640 AM

PHILIPSHER 5/12/06

Medical Certification; To Be Completed by Physician/Medical Examiner

1 - For State Registrar		Otate of W	iai yiai iu /	-	tificat				neman i		. No.		1000
1. Decedent's Name		_{ast)} Ph ili p H e r	schel S	HER					2. Date o Month		Day 2006	Year	3. Time of Death
	not institution, gi n Hospit	ve street and number a1)			Town, or ether	Location sda	of Death	· ****	,	4c. Count	ty of Death	
5. Social Security Nu 142-10-43		Sex 7. A 1 1 M 2 □ F	ge (In yrs. last b	rirthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of (Month)	, Day, Y	'ear) L 914		place (State or Foreigntry) Jersey
Usual Residence of			10.00	- 1						-,-		32 3	•
10a. State	10b. County		10c. City, To		cation 7111e							1	10d. Inside City Limits 1 ☐ Yes 2 ☐XNo
Maryland 10e. Street and Num	Montgo	mery	1	UCK	10f. Zip	Code				100	Citizen of	What Cour	
		oad #2133			101. 2.10	208	52			1 -		d Stat	•
11. Marital Status		12. Was Decedent	Ever in U.S.	13. \	Vas Deced	dent of Hi	spanic Or	igin? (Sp	ecify Yes of Rican, etc.	No-		ice - Americ	
1 Never Marrie	_	1 ty Yes 2 ☐ If Yes, Give Year or Dates:			⊺ □ Yes		Specify:			,	Speci		
(Specil	15. Decedent's E fy only highest gr	ducation ade completed)	168	(Give	lent's Usua kind of wo	rk done a	lurina mos	st of work	ing	16	b. Kind of E	Business/In	dustry
Elementary/Secon	idary (0-12)	College (1-4or	5+) Ce		ied]			coun	tant		Accou	unting	3
17. Father's Name (F	First, Middle, Las						18. Mothe	er's Name	e (First, Mic	ddie, Ma	iden Suma	me)	
	Jacob Sh	er						Hele	n Goo	dkir	1		
19a. Informant's Nar		(Type, Print)							al Route Nu				
Gerson St			20b. Place		THE RESERVE THE PERSON NAMED IN		t., N	-	ashin	7		2003	
1 Burial 2	Cremation 3	Removal from State	cemete	ery, cren	natory or o	ther place			Date			- City or To	
4 □ Donation :	5 Other (Speci		Etern		ight. Name an				14/06	Вс	yntor	ı Beac	ch, FL
		/		To	rchi	nsky	Hebr	ew F	unera				
SHOCK, OF HEAT	lianure. List only	aplications that cause one cause on each I	the death. Do	not ente	or the mod	e of dying	St.	cardiac o	was or respirator	hine y arres	ten,	DG 2	Approximate Interval Between
Immediate Cause (F disease or condition resulting in death)	Final 1	a	dial In		tion								Onset and Death 1 . Day
Sequentially list con-	ditions.	b											
if any, leading to infr cause. Enter Under Cause (Disease or in	nediale	Due to (or as	a consequence	ol).									
that initiated events resulting in death) La		c. Due to (or as	a consequence	of):		-						-	
	l	4		,									
IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal deat		Ectopic pro					_		ate of delive	ery Day Year
Part II. Other signific	cant conditions	contributing to death t	out not resulting	in the un	iderlying ca	ause give	n in Part I.		23e. D	id tobac	co use con	tribute to th	e cause of death?
Congest	ive Hear	t Failure			_				1	☐ Yes	2 🗆 No	3 ☐ Prob	ably 4 🖫 Unknown
Acute Re	enal Fai	lure							24a. W		24b.	Were auto	psy lindings available
Atrial T	Fibrilla	tion							_ p	utopsy arforme s 2[]		prior to cor death? 1 \(\text{Yes} \)	npletion of cause of
25. Was case referre		1.0000-8000						of Death	Check on				
1□Yes 2□XN	10	Hospital:		_			4 🗆 140	rsing Hor	me 5□R	esidenc	e 6 □Ott	ner (Specify	<i>'</i>)
27. Manner of Death 1 XNatural 2 Accident	5 Pending	28a. Đate of Inju (Month, Da	iry 28b. iy Year)	Time of Injury	M 2	8c. Injury Work 1 □ Y	at ? 'es 2 □ I		28d. Descri	be how	injury occur	red	
3 Suicide 4 Homicide	6 Could not be determined	28e. Place of In	jury - At home, fi c. (Specify)	arm, stre	et, factory	, office			28f. Locatio City or	n (Stree Town, S	t and Numl tate)	ber or Rura	l Route Number,
29a. Certifier	Certifying Pl	hysician: To the best	of my knowledg	e, death	occurred a	at the time	e, date an	d place, a	and due to t	he caus	e(s) and m	anner as st	ated.

State Registrar 29b. Signature

Eric J. Park, M.D.,

31. Date filed (Month, Day, Year) MAY 1

DHMH 17 Rev 1/2001

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

9901 Medical Center Drive, Rockville, MD

D 0060117

29d. Date signed (Month, Day, Year)

05/12/06

20850

			1 = For State Registrar	State of Ma	arylan		artment of F tificate of	lealth and M Death		giene Reg. No. 2	006	169	10
I	Physici /Medic		Decedent's Name (First, Middle, Harry Ja		Sande	ers			2. Date of Dea Month May 8,	Day	Year	3. Time of De 18:01	ath M
	Examin		4a. Facility Name (If not institution, Anne Arundel M		or			r Location of Death		4c. Cour	nty of Death		
	Funeral Director		5. Social Security Number 579–32–9696			last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day NOV 2	h /. Year)	9. Birthp Cour Wash	lel place (State or Fe ptry) lington,]	oreign DC
	Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND Anne	Arundel		y, Town or Lo					1	0d. fnside City L	
	with the	i Direc	10e. Street and Number 2010 Harbour G	ates Drive	Ant	310	10f. Zip Code 21401			10g. Citizen o	of What Cour	ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23s or 28s-f show eny injury or other treumatic event, I'm Medical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Marital Midowed 4 Divorced	12. Was Decedent Armed Forces?	Ever in U.	.S. 13.		dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- p Rican, etc.)		lace - Americ lack, White, cify: Wh		
21215-0036	id within 72 ho giene. er then "natu	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 12		i+)	(Give	dent's Usual Occup kind of work done DO NOT use retired obile Pa	during most of world)	king	16b. Kind of	Business/In		
Maryland	uld be file fental Hy rked oth	To Be (17. Father's Name (First, Middle, L Harry	ast)	San	ders		18. Mother's Nam	ne (First, Middle,	Maiden Sum		strong	
Mary	d 2 shouth and Manager treumate		19a. Informant's Name/Relationsh					and Number or Ru			m, State, Zip		
Baltimore,	Pages 1 an nent of Heal ant: If item 2 ary or other		Susan Carper – 20a. Method of Disposition 1XX Burial 2 Cremation 4 Donation 5 Other (Sp	3 □Removal from State	20b. P	lace of Dispo emetery, crer	sition (Name of natory or other place Hill Ceme	r. #307, ²⁰⁾ May 11 etery	, 2006	LS. MD 20c. Location Vashing	n - City or To		
Balt	permit. Departr Imports eny inj		21. Signature of Funeral Socvice L			Ge 29	Name and Address Orge P. 1 73 Solome	Kalas Fun ons Islan	eral Hon	ne, P.A Edgewat	A. ter, M	D 21037	
	Physician /Medical Examiner		23a. Party. Enfer the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	omplications that caused inly one cause on each line a. Due to for as	the death ge.	n. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ari	rest,		Approximate Interval Betwee Onset and Dea	n th
8760,	iate be executed hysicien and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertyping Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as		uence of):	. Wes	peet fa	cilula				
P.O. Box 68	law requires that the death centificate be executed as been signed by the attending physicien and 2 should be deteched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy	,			Date of delive	ny Day Year	r
	w requires that been signed b should be dete	ρ	Part II. Other significent condition	s contributing to death b	ut not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did to			e cause of death	
al Records,	The ate h	Completed	3						24a. Was a autops perfor	SV	o. Were autop prior to cor death? 1 Yes	osy findings avai npletion of cause 2 No	lable a of
f Vite	tysicien: The l is certificate he director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 3 ☐ No	Hospital: 1 ☐ Inpatie	nt 🌌	ER/Outpatien	t 3□ DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho	th <i>Check</i> only or		ther (Specify	·)	
Division of Vital	To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certifical completely filled in by the funeral director, to	Certification;	27. Mann of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	nt he	y Year)	28b. Time of Injury		y at k? Yes 2 □ No	28d. Describe hi				
<u>></u>	ital or Al		4 Homicide determin	building, etc	c. (Specify	()			City or Town	n, State)		l Route Number,	
	To the Hospital or Attent within 24 hours after deets To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Medical E	Physicien: To the best of xeminer: On the basis of and manner sta	examinat	wledge, death tion and/or inv	occurred at the ting restigation, in my o	ne, date and ptace, pinion, death occur	and due to the c red at the time, d	ause(s) and r ate and place	manner as st e, and due to	ated. the cause(s)	
)	with To 1	2	29b. Signature and title of certifier				29c. Licens	57028		9d. Date sign	ned (Month, I		
			30. Name and address of person w	, MD COE	Kud	gely -	tive. #2	31 A	mayol	w N	ID Z	HÔL	
	Sta Registr	_	31. Date filed (Month, Day, Year)	2006 32. egistra	ar's Signal	G. A	and the						

			1 - State Registrar	State of Maryla	nd / Dep		Health and	Mental Hyg	iene a. No. 200 (5 [69]
4	Physici /Medio Examin	al er	1. Decedent's Name (First, Middle, Las Edna Sellman 4a. Facility Name (If not institution, give Magnolia Nursin	e street and number)		4b. City, Town,	or Location of Dea	2. Date of Deat Month Ma. y	Day Year 9 2006	9:15 P ^M
	Funeral Director		5. Social Security Number 6. Social Security Number 219-12-3246	ex □ M 2ሺ F	s. last birthday, 85 Yrs.	Months Days				nthplace (State or Foreign ountry) ryland
	be filed within 72 hours after death with the Maryland at Hygiene. It hygiene do that then "naturel", or items 23a or 28a-f ehow other, the Madical Examinar must be notified at event, the Madical Examinar must be notified at	ai Director	10a. State 10b. County Maryland Prince (10e. Street and Number 631 Birchleaf A 11. Marital Status 1 Never Married 2 Married		City, Town or L eat P1	easant	1743	1	0g. Citizen of Whet C USA	10d. Inside City Limits 1 ☐ Yes 25 No ountry?
036	ours after death rei', or Items 2 Exerciter mu	Ω	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of If Yes, specify Cul		Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	te, etc.
Maryland 21215-0036	filed within 72 ho Hygiene. other then "natur ent, the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 8th	ducation de completed) College (1-4or 5+)	(Give	edent's Usual Occu e kind of work done DO NOT use retire Cafeteri	during most of wo	orking	16b. Kind of Business Prince Ge Co. Schoo	eorge's
ryland		To Be C	17. Father's Name (First, Middle, Last) Frank Bias 19a. Informant's Name/Relationship (1)		19b. Mail	ing Address /Stree	Ellen	ume (First, Middle, M L Davis Bural Boute Number	Maiden Sumame) City or Town, State,	Zin Code)
	1 and Health em 27 ther tr		Marvel Randall (20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	(Daughter)	631 Place of Disp cemetery, cre	Birchle	af Ave	Seat Pl	easant, 1 20c. Location - City or	Md. 20743 Town, Stete
Baltimore,	permit. Pages Department of I Important: If it eny injury or o		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	y) M	₩ M	Cemetery Im. Rees 121 West	ess of Facility	s Mortu	ary, P.A	•
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the de	eath. Do not en	iter the mode of dy	ing, such as cardia	ac or respiratory arre	est.	Approximate Interval Between Onset and Death Years
68/60,	icate be executed physicien and s the burlat-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons						
O. Box	The law requires that the death certificat ale has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o	tel death 3	□Ectopic pregnand □ Other (specify) _	ey .		23d. Date of de Month	livery Day Year
Hecords, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions of	ontributing to death but not r	esulting in the (underlying cause g	ven in Part I.	23e. Did tot	pacco use contribute to	o the cause of death?
Vital Rec		e Completed	7.	vicerz			Of Blace of Do	24a. Was a autops perform 1 Yes 2	y prior to death?	utopsy findings available completion of cause of 2 No
Division of Vi	ng Phys Iter this Ineral di	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Adural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		of 28c. Inju	her: 4 Nursing lary at ork? Yes 2 No	Home 5 Reside	ince 6 Other (Spe	
DIX	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		4 Homicide determined 29a. Certifier 1 Certifying Ph		nowledge, dea	th occurred at the I	ime, date and plac	City or Town	use(s) and manner a	s stated.
)	To the Hospitel within 24 hours a To the Funerel completely filled	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number	29	9d. Date signed (Mont	th, Day, Year)
			30. Name and address of person who			Print)	uny Rd	Hyatts	ille Mi	20781
	Sta Registi		31. Date filed (Month Day, Year)	Registrar's Sig	nature	and a				

06-03059 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Roger Alan Trott 2006 16912 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Medical Examiner Roger Alan May 5, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Admiral Drive @ Mooreland Parkway Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Director 212-88-4675 1 X M 2 F 34 06/30/1971 Usual Residence of Decedent 10c. City, Town or Location JU permit Pages I and 2 should be filed within 12 nours after ucaus with the Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once, Caroline Maryland es 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Ridgely Director 10e. Street and Number 10f. Zip Code 407 Maryland Avenue 21660 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married White, etc. Yes 2 X No 3 Widowed Divorced If Yes, Give Year Yes 2 X No specify. 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 10 Construction Worker 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Preston Russell Trott Stella Fischer 19a. Informant's Name/Relationship (Type, Print) Stella Trott - mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 8urial 2 yCremation 3 Removal from State Metropolitan Donation 5 Other Specify al Service License 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical a. gunshot wound of head Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit Physician/Medical UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2248 hrs 8. Date of 8irth (MM/DD/YYYY) 9. Birthplace (State or Country) Maryland 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? 14 Race - American Indian, 8lack, Specify: White 16b. Kind of 8usiness/Industry Construction 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Maryland Ave. Ridgely, Maryland 21660 20c. Location - City or Town, State 05/18/2006 Alexandria, VA 22. Name and Address of Facility Advent Funeral Service 7211 Lee Hwy. Falls Church, VA 22046 Approximate Interval 8etween Onset and Death Division of Vital Records, P.O. Box 68760, into r Attending Physician: The law requires that the death certificate be executed icate has been signed by the attending physician a page 2 should be detached for use as the burial -Day Year 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b Were autopsy findings available 24a. Was an autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi 25. Was case referred to medical funeral director, 26.Place of Death (Check only one) Be Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene ۵ 1 V Yes 28a. Date of Injury (Month, Day Year) May 5, 2006 27. Manner of Death 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred Subject shot by police 2238 hrs 1 Natural Pending Yes 2 V No in by the Certificati 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be (Specify) Local Street Admiral Drive @ Mooreland Parkway, Annapolis, 4 🗹 Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 6, 2006 30. Name and address of person who completed cause of death (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Registrar's Signatur State 2006 Registra

			1 - For State of Maryland /			f Health a	nd Mer		2000	16012
	Physici		Decedent's Name (First, Middle, Last)		imouto c	J. Dodin		Date of Death		3. Time of Death
	/Medic	al	George Oliver Thompso		4h Cihi Taur	n, or Location of		May 15	2006	0/16A M
	Examin	er	Calvert Memorial Hospital			e Fred		ζ.	4c. County of Dea Calvert	ath
	Funeral Director		5. Social Security Number 5.08−18−1349 6. Sex 12 M 2□F 84	birthday)_ Yrs.	If Under 1 Ye Months Da		Min.	Date of Birth (Month, Day,	Year) C	rthplace (State or Foreign country) ebraska
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Loc	ation					10d. Inside City Limits
	e Man Sa-f sh	ctor	Maryland Calvert St 1	Leon	ard					1 ☐ Yes 2 ☑ No
	h with th	al Dire	10e. Street and Number 5450 Bayview Ave.		10f. Zip Cod	₀ 0685		10	g. Citizen of What C United	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itema 23a or 28a-f show any injury or other traumatic event, Ita Medical Ever their most be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 12. Yes 2 □ No 13. Yes 3. Give Year or Dates: 43-4!		/as Decedent of Yes, specify C	of Hispanic Orig Cuban, Mexican, No Specify:	in? (Specify Puerto Ric	Yes or No- an, etc.)	14. Race - Am Black, Whi	te, etc.
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Maryland	d 2 sho								City or Town, State,	Zip Code) and 20657
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	spital hours a meral [29a. Certifier 1 Certifying Physicien: To the best of my knowledge	ge, death (occurred at the	time, date and	place, and	due to the cau	se(s) and manner as	s stated.
	the Ho hin 24 the Fu	Medical	one) 2 Medical Examiner: On the basis of examination a and manner stated.	ind/or inve	estigation, in m	y opinion, death	occurred a	t the time, date	e and place, and due	to the cause(s)
)	To COC	-	29b. Signature and title of certifier			ense number 6039 c	>		1. Date signed (Mont) $1.5/2 \epsilon$	
	0 L I		30. Name and address of person who completed cause of death (Item 23a)) (Type, Pi		,			7	
0	Sta	te	30. Name and address of person who completed cause of death (Item 23a) ADEB JABER 100 H05 P1 31. Date filed (Month, Day, Year) WAY 1 2 2006	TAL	120.	PRINC	CE FA	EDERI	ck, MD	20678
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		•	For State Registrar	State of Ma	arylan		artmen			and Me		giene	006	16914
	\$ 18 m	4	Decedent's Name (First, Middle, La	st)							2. Date of De	ath		3. Time of Death
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	cete pag	S									perfo	rmed? 2☐No	death? 1 ☐ Yes	2 No
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Di. To the Hospital or	within 24 hours effer death. To the Funerel Director: After this certificete his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Pt	ysician: To the best	of my kno	wledge, death	occurred	at the tim	e, date an	d place, ar	nd due to the	cause(s) a	nd manner as	stated.
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Amend #5, per FD, 199-22-4190, 06-03165 5/19/06 Please Type or Print in Black Indelible Ink 06-03165 5/18/06, drw Raymond Tomco, Sr. State of Maryland / Department of Health and Mental Hygiene 2006 | 69 | 5 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day May 10, 2006 Year Medical Examiner 1436 hrs Raymond Joseph Tomco, Sr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8335 Swallow Lane 5. Social Security Nurope 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Days Months Hours Director 199-22-4109 77 ₁ma,le₂□F Oct. 22 1928 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits 23a or 28a-f show notified at once. Calvert 1 Yes 2 X No St. Leonard Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 595 Calvert Beach Road 20685 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 Yes 2 No
4 Divorced If Yes, Give Year korea 3 XWidowed 1 Yes 2 X No specify: Specify: white ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th construction carpenter other the Me 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) marked Be Michale Tomco Mary Plichta 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond J. Tomco, Jr. - son 595 Calvert Beach Rd. St. Leonard mD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) May 20a. Method of Disposition 20c. Location - City or Town, State 17 2006 1 Burial 2 Cremation 3 Removal from State Alexandria Virginia Metropolitan Funeral Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home To Pd. Port Porblic MD 20676 23a. Part I. Enter the disease, or complications that caused the death. Do not en-Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Exsanguination Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Multiple Dog Bite injuries Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed and tran: ian/Medical g physician the burial -UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b Was decedent pregnant in the past 12 months? Fetal death 3 Ectopic pregnancy Year Day Pregnant at time of death Physic 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ö þ Division of Vital Records, P. Arteriosclerotic Cardiovascular Disease; Coumadin Therapy Yes 2 🗸 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No ✓ Yes To the Hospital or Attending Physician; 25 Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other₄ DOA ER/Outpatient 3 Nursing Home 5 Residence 6 🗸 Other: Scene After this 1 🗸 Yes ٩ No 28a. Date of Injury (Month, Day,Year) FOUND: Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject mauled by dogs FOUND: Natural Yes 2 🗸 No Pending May 10, 2006 1315 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide (Specify) Single Family Home 8335 Swallow Lane, White Sands, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated nature and title of dertifier, 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. May 11, 2006 30 Name and address of person who completed cause-o death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month, Day, Year) Registrar's Signature State 2006 Registrar

			1 - For State Registrar	State of Marylan		artment of H		Re	g. No. 4 UU b	16916
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of Death Month	Day Year	3. Time of Death
e:	/Medic			Vorndran		4b. City, Town, or	Location of Dog		10, 2006 4c. County of Dea	12:15 P M
	Examin	ier	Maplewood Park Pla 9707 Old Georgetow	m Road		Beth		и		
*	Funeral		5. Social Security Number 6 Se	7 Age (In vrs	last birthday)	If Under 1 Year	If Under 24 Hrs		Montgom 9. Bir	hplace (State or Foreign buntry)
	Director		J/3-24-4014	M 2□F 80	Yrs.	Months Days	Hours Min	Oct. 16	, 1925 Nev	v York
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
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	r 28a	Irec	10e. Street and Number	_y	inebaa	10f. Zip Code		10	g. Citizen of What Co	ountry?
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	ir dea	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 194		Was Decedent of His f Yes, specify Cubar	spanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
20	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced	If Yes, Give 194	6	1□Yes 2X No	Specify:	, 5.6.7	Specify:	_
2-003a	n 72 hours after "natural", or its		15. Decedent's Edu	Year or Dates:	16a Deced	ient's Usual Occupa	tion	1 1	6b. Kind of Business	/hite
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aua	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)					me (First, Middle, M	aiden Sumame)	
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Mar	permit. Pages I and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If tem 27 te marked other then "n eny injury or other traumatic event, the Medione.		19a. Informant's Name/Relationship (T)	, ,					City or Town, State, 2	
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saltimore,	nit. P artme ortan injur	-	21. Signature of Funeral Service Licens	Cr	emator	У	1	Vol Funera		VIIgIIIIa
Ď	De de de de de de de de de de de de de de		1 Henry x	Fran-D	140	22 Wa	22 Wisc	onsin Ave	non7.W.	
6			23a. Part1. Enter the distase, or complished, or heart failure. List only or	ications that caused the death	n. Do not ente	er the mode of dying	, such as cardia	c or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Prostate Ca	ncer w	rith Metas	tasis		İ	Onset and Death
	/Medical Examiner	Ì	resulting in death)	Due to (or as a conseq		100000	CUBID			
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מכא	law requires thet the death certific as been signed by the attending p 2 should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of del	
	the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown		Other (specify)			Month	Day Year
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>	tending Physician: The lav Boath. tor: After this certificate has the funeral director, page 2	To B	examiner? 1 ☐ Yes 2 🔀 No	ospital: 1 Inpatient 2	ER/Outpatient					afy)Asst.Livin
S	ng Ph fter th nerat		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how		,,
2	eath. or: A	Certification:	2 Accident investigation				es 2 □ No			
<u> </u>	or At fler d Direct in by	ıtiti	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director.		29a. Certifier 1X Certifying Phys	ician. To the best of and	wlodes desir					
	Hos 24 h Fun etely	edical	(Check only one)	sician: To the best of my knowner: On the basis of examinal and manner stated.	wieuge, death tion and/or inv	occurred at the time estigation, in my opi	a, date and place nion, death occu	, and due to the cau irred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To th within Fo th compli	Me	29b. Signature and title of certifier	,		29c. License	number	290	d. Date signed (Monti	, Day, Year)
	12		Mulym	Van	220	D31 79	1		y 11, 200	
			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, I	Print)	-			
			Merlyn K. Vemury,				r Spring	g, Marylar	nd 20902	
	Sta Registr		31. Date filed (Mooth, Day, Year) MAY 15 20	32 Registrar's Signal	La Land	ule				

			For State Registrar		epartment of Health and Certificate of Death	Reg.	7 1601 0007
	Physici /Medio		Decedent's Name (First, Middle, Last, ANNA LORETTA	WELKIE		2. Date of Death Month MAY 22	Day 2006 3. Time of Death 7:15 A M
	Examin	er	4a. Facility Name (If not institution, give ST • MARY 'S NURS	NG CENTER	4b. City, Town, or Location of Deat LEONARDTOWN		4c. County of Death ST. MARY'S
	Funeral Director		162-20-7999	IM OME	day) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		ar) 9. Birthplace (State or Foreign Country) L926 PENNSYLVANIA
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, It a Madical Examiner must be notified at 90ce.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND ST • MA 10e. Street and Number 22680 CEDAR LAN 11. Marital Status 1 Never Married 2 Married (Specify only highest grade) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) WENDELL BABUSIA 19a. Informant's Name/Relationship (Ty SUSAN M • DELAHA 20a. Method of Disposition 1 Namidal 2 Cremation 3 Para All	Section 16a. 16a	ARDTOWN 10f. Zip Code 7 20650 13. Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puer 1 □ Yes 2 ☒ No Specify: Decedent's Usual Occupation Give kind of work done during most of work done during mos	pecify Yes or Noto Rican, etc.) 16b. rking PE me (First, Middle, Maid E SAKALA ural Route Number, Cit, D • , LEONAR Date 20c.	10d. Inside City Limits 1XXes 2 □ No Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: WHITE Kind of Business/Industry CRFECT PARTS en Sumame) y or Town, State, Zip Code) CDTOWN, MD 20650 Location - City or Town, State
8	Physician		1 -1 0	MODATS	22. Name and Address of Facility RAYMOND FUNERA LA PLATA, MARY It enter the mode of dying, such as cardial	L SERVICE LAND 2064 correspiratory arrest,	Approximate Interval Between Onset and Death
8760, 0	eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):		
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of	Phys ir this aral di	F=-	27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outp 28a. Date of Injury 28b. Tin	atient 3 DOA 4 Nursing H	ome 5 Residence 28d. Describe how in	
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	10		William D. Buso	haleted cause of death (Item 23a) (To	organit Rol Leonard	town. MD	5.37-06. 20650
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7	the same		1. Decedent's Name (First, Middle, Last)	2	2. Date of Death Month	3. Time of Death
	Physicia /Medic		Margaret M. Weisman	=	May	8, 2006 6:10P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		á.	Montgomery General Hospital	Olney		Montgomery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 106-22-1068 77 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Ye) Aug. 11,	1928 Sirthplace (State or Foreign Country) New York
	and the		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Low	ocation		10d. Inside City Limits
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	death me 2	Funeral		Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No-	14. Race - American Indian,
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2-0	72 h	Completed by	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16b	. Kind of Business/Industry
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ē,	Head It Head		20a. Method of Disposition 20b. Place of Disposition		te 20c	. Location - City or Town, State
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Iteme 23e or 28e-f ehow eny injury or other traumatic event, the Modical Examination and the notified at once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Oanzansky-Goldberg		
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Division of Vital	9 4 4 5	Certification:	3 Succes determined determined determined building, etc. (Specify)	treet, factory, office	City or Town, S.	t and Number or Rural Route Number, fate)
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	dical C	29a. Certifier (Check only 29a. Medical Examiner: On the best of my knowledge, deal 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deal 29a. Certifier	th occurred at the time, date and place, are nvestigation, in my opinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	thin 2 the the imple	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			M.D.	DO058770	1	05/08/2006
•	10		30. Name and address of person who completed cause of death (Item 23a) (Type			. , , , ,
				hilip Drive Olney	Mary L	ond 20832
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Funeral Director		5. Social Security N 119–66–2831	lumber	female female	7. Age	(In yrs. last bi	irthday)	If Under Months	1 Year Days	If Under 2 Hours		Date of the Sept. 2		1/DD/YYYY) 56	Foreign	nplace (St n entry l\ew	
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Physician		23a. Part I. Enter the			caused th	ne death. Do	not enter	5 Broom the mode of	dying, s	such as card	diac or re	spiratory a	rrest, sh	ock, or hea	rt		mate Interval
/Medical Examiner		Immediate Cause (Final disease	a Seizure											- 3		Death
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	iner	if any, leading to in cause. Enter Under	nmediate erlying Cause	Due to (or as	a consec	quence of):											
50 7 T	EX ST	(Disease or injury t events resulting in		Due to (or as	a consec	quence of):											
oe evec seium au reist	dical	X UNPENDED		AMENDED	item	#23a,27,	perÆ	,g857,7	/13/0	06 TT							
Box 68760, e-leath certificate be	sician/Medic	IF FEMALE: 23b. Was decedent past 12 months	\$?	he 1 Live 4 Preg	birth Inant at ti	e of pregnand me of death	2 F	etal death	3 [fy)	Ectopic p	oregnancy	,	23	Month		ay	Year
0 -	Phy			tions contributing		but not result	ing in the	underlying	ause gi	ven in Part	I.	23e. Dio	tobacco	use contrib	oute to t	he cause	of death?
O. Test that the	S D											1 Y	es 2	√ No 3	Prob	ably 4	Unknown
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Rec	Com											1 Yes	formed?		eath? Yes	. 2	No No
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	cation: To	1 Yes 27 Manner of Dea 1 X Natural	2 No th	(Mon	e of Injur th, Day,Ye	y 28b	o. Time of		Bc. Injury	y at Work?	28	-		jury occurre	_		
Division	ficat	2 Accident 3 Suicide	Inve	stigation	ace of Inju	ıry - At home,	farm, stre	eet, factory,	office bu	uilding, etc.	28			and Numbe	r or Rur	al Route I	Number, City
#5	Certifi	4 Homicide		rmined (Specify	1)							or Town	, State)				
To the He	adical	(Check only one) 2 ✓		hysician: To the be iminer:On the basis and manner	s of exam												
- 5 =	Winds Section	29b. Signature and	************		- 0			29c.	License O.C.N	number				Date signe		th, Day,Y	ear)
		10.01	ress of person	who completed ca	use of do	ath (Item 222	1)		U.U.IV	/i.L.			Ivia	y 21, 200		<u>.</u>	
		Margarita K		Assistant Me		,		Penn Stre	et, Ba	altimore,	MD 21	201					
		31. Date filed (Mor	th Day, Year)		istrar	s Signature	A	ale									
	hii ki						-	- 4777 FT									

DHMH 17 R 2000 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Thomas Linwood Yoe 12, 2006 8:25 P. May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner South River Health & Rehab Anne Arundel Edgewater If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Months Oays Hours Yrs. 83 Aug. 20, 1922 Maryland Director 220-24-9260 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "neturel", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at Huntingtown 1 ☐ Yes 2 No MD Calvert Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20639 3850 Town Road U.S.A. old 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within all Hygiene. agriculture College (1-4or 5+) Elementary/Secondary (0-12) construction farmer / carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 and 2 should be fill ment of Heelth and Mental H tent: If item 27 is marked of Be Williams Elsie Weems 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2351 Hunting Fields Dr., Huntingtown, MD Jim Yoe, nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of importent: If eny injury or once. Miranda Cemetery 05-16-06 Huntingtown, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Linensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 erlack 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** Metastatic Rectal disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner signed by the attending physicien and d be deteched for use es the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hibrillation 1 Yes 2 No 3 Probably 4 donknown been s 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 LINO Division of Vital To the Hospitel or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 2Ba. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending nours efter death. nerai Director: Att 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 2Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier YW D.50653 5-15-2006 SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C Deale churchton Road Deale MD 31. Date filed (Month, Day, Year) 32. Registras Signature State MAY 1 6 2006 Been & Registrar

	•	For State Registrar	State of M	laryland /		artmen <i>rtificat</i>			and Me		giene	006	16921
Physicia	-	1. Decedent's Name (First, Middle, Last) Virg	inia			Z.	lrno	1d		2. Date of Dea Month May	Day	Year 2006	3. Time of Death 5:08 A M
/Medica Examine		4a. Facility Name (If not institution, give since the second seco	reet and number;		a 1	4b. City,	Town, or	Location o	f Death	1	4c. C	ounty of Death	
Funeral Director		5. Social Security Number 6. Sex 557-32-6819 1□	7. Ag	ge (In yrs. last			1 Year Days	If Under 2 Hours	Min.	8. Date of Birtl (Month, Day ug 4,	h , Year) 1915	9. Birthp Coun IL	lace (State or Foreign try)
ith the Maryland or 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Frederi 10e. Street and Number	ck	10c. City, To			Code				10g. Citize	n of What Coun	0d. Inside City Limits 1 ☐ Yes 2 [No try?
urs a	by Funeral Director	6804 Falstone Driv 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	e. 2. Was Decedent Armed Forces' 1 Mayes 2 ☐ If Yes, Give Year or Dates:	? No		_			gin? (Spec , Puerto R	U ify Yes or No- lican, etc.)		. Race - Americ Black, White, pecify: Whit	etc.
d within 72 ho giene. or then "netur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12			(Give lite. I	dent's Usua kind of wo DO NOT us creta	rk done d se retired)	uring most	of working	g	16b. Kind	of Business/Ind	^{dustry} unk
Mental Hyg Mental Hyg arked othe attc event,	To Be C	17. Father's Name (First, Middle, Last) Hugh Patton Hanna						Gerti	rude	(First, Middle, 01inda	Domh	off	
ages 1 and 2 shr out of Health and it: If item 27 le m y or other traum		19a. Informant's Name/Relationship (Type Lloyd Arnold/husbar 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 4 ≦ Donation 5 □ Other (Specify)	nd	20b. Place	804	Fa1st	one	Drive		derick,	MD 2	Fown, State, Zip 21702 Ition - City or To	
permit. P Depertme Importan eny injur.	İ	21. Signature of Fundal Service License	ade Vi	ctor	St Be	Name ar Late A	d Addres Anato	s of Facility My Bo	oard 1201	655 W.	Balt	imore S	treet
Physician /Medical Examiner		23a. Part1. Inter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in dealh)	cause on each	d the death. Dine.	5	er the mod	e of dying	, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
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eg les	ò	Part II. Other significant conditions con	ributing to death	but not resulting	g in the u	nderlying c	ause give	n in Part I.		23e. Did to		,	e cause of death? ably 4 DUnknown
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the Hospita thin 24 hours the Funerel mpletely filled	Medical C	one)	er: On the basis and manner s	of examination	and/or in	vestigation	, in my op	inion, deat	th occurred	d at the time, o	date and pl	lace, and due to	the cause(s)
2T W 10 0		30. Name and address of person who co	mpleted cause of	death (Item 23	a) (Type	Print)	000	604	17		5/2	22/06	,, / 64./
Stat Registra		Hemen Sheih 31. Date filed (Month, Day, Year) MAY 3 1 201	MD, 6	5-C T	hor	nas	Jo	Linse	ers	Dr,	Trec	levren	MD 2176

				1 - For State Registrar	State of Marylar	•	ent of Health and ate of Death		ene 2006	16922
_		Physici /Medio	cal	Decedent's Name (First, Middle, La NATALIE 4a. Facility Name (If not institution, gi	ANDERS		ity, Town, or Location of Dea	2. Date of Death Month MAY 2	Day Year 6 2006 4c. County of Death	3. Time of Death / 0 45 A M
		Examir Funeral Director	ner	5. Social Security Number 6. 048-26-1216	HOSPICE Sex 1 M 20 F 7. Age (In yrs.		der 1 Year If Under 24 Hrs	8. Date of Birth	BALTO	
		the Maryland 28a-f ehow	ector	Usual Residence of Decedent 10a. State 10b. County 10b. Street and Number	Timore 10c. Ci		PARKUILLE Zip Code	100	, Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No
·	9	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "netural", or items 23a or 28s-f show or other traumatic event, the Mudical Exama architels craffied at	Funeral Director		12. Was Decedent Ever in U Armed Forces? 1 Dyes 2000 If yes, Gire	J.S. 13. Was De	2/23 4 icedent of Hispanic Origin? (: ipecify Cuban, Mexican, Pue		U · S · A 14. Race · American Black, White,	4 can Indian,
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2006	Maryland 21	S should be filled wand Mental Hygiele marked other tale	To Be Co	17. Father's Name (First, Middle, Las Mathew Ker	114		Ethe	me (First, Middle, Ma 2 (De G	JoiR.	
26, 20		Pages 1 and 2 shout of Health and int: If item 27 ie miry or other traum		19a. Informant's Name/Relationship Debra — 5 he 20a. Method of Disposition 1 □ Burial → Germation 3	20b.	2809 07 Place of Disposition (ess (Street and Number or R AKC (CST AQUE) Name of or other place)	BA Ito.	MD 2123	own, State
MAY	Baltimore,	permit. Pages 1 and 2 Department of Health is important: if item 27 i eny injury or other tre		4 Donation 5 Other (Spec 21. Signature of Funeral Service Lice		14VIEW Cr 22. Name PAUL 752	ematores of Facility STELLA FUN 7 harfocal RI	eral Home	3A (TO. MD L, PA MS 2123	4
	68760, <	Physicien and was executed by some and was in the private of the p	dical Examiner	28a. Parth. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect C. Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect C. Due to (or as a consect Due to (o	R quence of): quence of):	node of dying, such as cardia	ic or respiratory arres	t,	Approximate Interval Between Onset and Death
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NATALIE /	Vital Records,	as b	Be Completed	25. Was case referred to medical examiner?	1			24a. Was an autopsy performe 1 Yes 2	d? prior to co	opsy findings available mpletion of cause of
N	Division of V	ing Phys	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatin 3 Suicide 6 Could not	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how		
	Divi	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 ☐ Homicide determined		owledge, death occur	red at the time, date and place	City or Town,	se(s) and manner as s	tated.
•		To the H within 24 To the Fi	Medical	29b. Signature and title of certifier 30. Name and address of person who	and manner stated.		29c. Licanse number		Date signed (Month,	
		Sta Regist	ate rar	DR. TARIO MAHMO 31. Date filed (Month, Day, Year) MAY 3 1 200	OD 2300 DULAN	EY VALLEY	RD. TIMONIUM	, MD 21093		

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MAY 26, 2006

		1	For State Registrar	State of M	laryland /		rtment of H tificate of I		Mental Hy	giene Reg. No. 20	06	16923
-64			Decedent's Name (First, Middle, L.	ast)		40.	4		2. Date of De	eath Day	Year	3. Time of Death
	Physicia /Medic	al	Patricia			Abo	ad-Sar		may	24 0	2006	23:29 M
F	Examin		4a. Facility Name (If not institution, ga					Location of Death		4c. County	of Death	
			The Johns Hop 5. Social Security Number No. 26.		ge (In yrs. last	hirthday)	Baltiv ff Under 1 Year	MOY (C/	' /	irth	9. Birth	place (State or Foreign
п	Funeral Director		5. Social Security Number No.	1 □ M 2 💢 F	50	Yrs.	Months Days	Hours Min.	August	rth ay, Year) 26,1955	Morc	
1	ס		Usual Residence of Decedent		140 01 7							10d. Inside City Limits
	anylan	_	MD 10b. County Montgo	omerv	10c. City, T		hesda					1 XYes 2 No
	Ne Me Me Colline	ecto	10e, Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntry?
	72 hours after death with the Maryland instural; or Itema 23a or 28a-1 show dical Exambar must be notified at	by Funeral Director	9202 Wilmett	Court			2081	L7		Spai	n	
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9	or Ite	Ē	1 ☐ Never Married 2 Marned	1 Yes 2			Yes 2 No	Specify: Spa		Specia	T.18	nite
003	ural',	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates		Ga Dagad	lent's Usual Occup			16b. Kind of B	lusiness/Ir	adustry
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ylaı	should be ind Mental ind Mental in marked o	D D	Diego Abad			200		Susar			C1-1- 7:	= Code)
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e,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itema 23a or 28a-1 ahow or other traumatic event, If a Medical Examinational be notified at		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of natory or other place	20)	Date	20c. Location	- City or T	own, State
nor	ages ant of nt: If it		1 Burial 2 Cremation 3				Eupopen	6/1	6/06	Rabap,M	brocc	O .
Baltimore, Maryland 21215-0036	permit. Pages 1 am Department of Heali Important: If item 2 any injury or other ance.		21. Signature of Funeral Service Lic		,	22	Name and Addre Charles L. 1501 East	ss of Facility Stevens F	uneral H	me Inc. MD 21230		
	TOTEG		23a. Part1. Enter the disease, or ox shock, or heart failure. List on	implications that caus	sed the death.							Approximate Interval Between
	Discriptor		fmmediate Cause (Final	/ 22	. 4							Onset and Death 2 UCATO
1	Physician /Medical		disease or condition resulting in death)	O	aStatiC as a consequer		ng canc	(1)				a year
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	and and I-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	as a consequer	nce of):						
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Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me of pregnanc 2 Detailde		∃Ectopic pregnanc	у			ate of delin	very Day Year
	the atte	sicia	in the past 12 months? 1 □ Yes 2 □ No		t at time of deat		Other (specify)	<u> </u>			Otto	Day
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fVi	Physician: rthis certifica ral director, I	To B	examiner? 1 Tes 2 No	Hospital: 1 X Inp		₹/Outpatie		4 Nursing	-	sidence 6 🗆 O		rity)
0	ing Phys n. After this funeral di		27. Manner of Death 1 Naturaf 5 ☐ Pending	28a. Date of (Month,	njury 2: Day Year) 2:	8b. Time o Injury	Wo		28d. Describ	e how injury occu	ırred	
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Division of Vital	or At after of Direction by	Certification:	4 Homicide determin	ed 286. Flace of building	, etc. (Specify)	o, iaiiii, si	reat, factory, office		City or 1	own, State)		
_	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		(Check only 2 Madical E	Physician: To the be marked the base	is of examinatio	edge, deat n and/or in	th occurred at the to	ime, date and plac opinion, death occ	e, and due to thurred at the time	ne cause(s) and n e, date and place	nanner as , and due	stated. to the cause(s)
	thin 2, the F mplet	Medical	one) 29b. Signature and title of certifier	and manne	r stated.			se number		29d. Date sign		
7	8 18 1		Anu Gupta	. Modice	al Dor	tor	Ro	5-000)	may	24,	2006
	1-		20 Name and address of parcon to	to completed cause	of death (Item 2	3a) (Tyne	Print)					
	9		Any Guota, The	Johns Hoo	Kins Ho	spital	, 600 Nor	th Wolfe	STREET, B	altimore,	Maryl	and 21287
2		ate	31. Date filed (Month, Day, Year) MAY 3 1 2	32. Reg	jistrar's Signatu	re Ano	Les .					
	Regis	trair	MALSTY	JUU ARREA	The state of	1 ale						

Amend item# 19a, perFh, (855, 5/31/200 TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Binns 22: 11 PM 2006 /Medical 22 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Medical (est NA Munyland nousity of Buthout 8. Date of Birth If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** G Hours 1 M 2 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic svent, the Medical Examinar must be notified at 1√Yes 2 No Director 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ZOV 0 Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ N6 þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) IM KITE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ H 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) deman. 19a. Informant's Name/Relationship (Type, Print) item 27 ls Horiz 10 605 · roleioz kevi other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate ō PO BOX 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō 2966 Department of Important: If any injury or soce. 27/06 BPLTO md 21 4 ☐ Donation 5 ☐ Other (Specify) RO CATOMATORY 21. Signature of Funeral Service Licens 222) W. NORTH ANE Joseph Kuss BALTO Md 21216 Hurria 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner respiratury Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical attending pl 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 1 ☐ Yes 2 2 No 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Plubetes 3 Probably 4 Unknown 1 Tes 2 No certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 Ro 1 ☐ Yes Division of Vital Hospital or Attending Physician: the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1@Inpatient Certification: To 1 Tes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 ONatural Injury within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AU 4176435H 16657 (will 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore 22 S ane 32. Degistrar's Signature 31. Date filed (Month, Day, Year) State MAY 3 1 2006 Registrar

06-03544 William Bland

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No Physician/ Decedent's Name (First, Middle,Last) 2. Date of Death **LExamine** Month Day May 22, 2006 1120 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Deat 2753 Baker Street Baltimore **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9 Birthplace (State or Director Months Days Hours oreign 1X M 2 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ust be notified at once, permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she rigury or other traumatic event, the Medical Examiner must he notified at once 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. the Medical Examiner must be 1 Never Mamied Armed Forces? Race - American Indian, Black, Yes Widowed If Yes, Give Year Divorced \$ Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) Completed 16a. Decedent's Usual Occupation (Give kind of work done Elementary/Secondary (0-12) during most of working life. DO NOT use retired) College (1-4 or 5+) 7. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Sur Be Informant's Name/Relationship (Type, Print) Brother 19b. Mailing Address (Street and Number or Rura/Foute Number, City or Town, State, Zip Code) 20a. Method of Disposition Baltimore. 20b. Place of Disposition (Name of cemetery, 2 X Cremation 3 Removal from State Date Burial crematory or other place) 6-2-06 Donation 5 Other Specify Metro Crematory ature of Funeral Servige License 22. Name and Address of Facility used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hysician ease, or comis re. List only one cause on each line. Approximate Interval ledical Between Onset and Imme late Cause (Final disease a. Atherosclerotic Cardiovascular Disease **x**aminer Death or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical signed by the attending physician be detached for use as the burial UNPENDED X AMENDED Division of Vital Records, P.O. Box 68760, ital or Attending Physician: The law requires that the death certificate be t 20b per fh g856 6-7-06 vt IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23d. Date of delivery Live birth past 12 months? 3 Ectopic pregnancy Fetal death Day Month Year Pregnant at time of 1 Yes 2 No 9 Unknown 5 Other (Specify death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Seizure Disorder Completed 1 Yes 2 No 3 Probably 4 Vunknown 24a. Was an 24b. Were autopsy findings available certificate has autopsy prior to completion of cause of performed death? Yes 2 V N Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical Be 26.Place of Death (Check only one) Hospital: After this 1 Yes Other₄ 2 Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 Other: Scene 27. Manner of Death 28a. Date of Injury (Month, Day, Year Certification: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Director: Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City determined Homicide or Town, State) 29a. Certifier 1 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 26, 2006 and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year MAY 3 1

State Registrar

gistrar's Signatus

2006

			1 - For State Registrar	State of Marylar		ent of Health and ate of Death		iene	16926
			Decedent's Name (First, Middle, La	st)			2. Date of Deat	h	3. Time of Death
	Physici /Medi		MAURICE	ANTHO	NY BE	VERAGE	Month	27,2006	11.28 AM
	Examir		4a. Facility Name (If not institution, gives St. Aghes	e street and number) Hospital	/	ity, Town, or Location of Deal	th	4c. County of Death	'A
	Funeral Director		5. Social Security Number 220 - 68 - 7165 Usual Residence of Decedent	Sex 7. Age (In yrs	7 Yrs. Mont	der 1 Year If Under 24 Hr hs Days Hours Mir		Year) Cour	lace (State or Foreign http:// RI/LAND
	yland sow		10a. State 10b. County	10c. C	ity, Town or Location			1	Od. Inside City Limits
	be filed within 72 hours after deeth with the Maryland nat Hygiene. sd other then "neturel", or iteme 23e or 28e-f show event. The Medical Exerting must be routiled at	Director	MARYLAND 10e. Street and Number	UIA	3	ALTIMORE Zip Code		/	1 Yes 2 □ No
	with Be or	ā	231/11/1	I ANIMAIT	STREET	210 Code	1/2	Og. Citizen of What Cour	ntry?
	ne 23	Funerai	11. Marital Status	12. Was Decedent Ever in L		ecedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Americ	an Indian.
36	s after or ite	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		specify Cuban, Mexican, Pue s 2 Ž No <i>Specify:</i>	rto Rican, etc.)	Black, White,	etc.
9	2 hour	edt	15. Decedent's E		16a. Decedent's U	Isual Occupation		16b. Kind of Business/Ind	dustry
215-0036	thin 7:	Completed	(Specify only highest gr Flementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	work done during most of we Tuse retired)	orking		,
121	filed wi Hygien other th		17. Father's Name (First, Middle, Last	1	LA	BORER	15	COMMERCIA	AL LAUNDRY
Maryland	should be find Mental Find Men	To Be	FREDRICK		VERAGE		me (First, Middle, M	1	DNV
ary	2 should land Meni sand Meni sa marke eumetic	-	19a. Informant's Name/Relationship			ess (Street and Number or F	ural Route Number,		
	s 1 end 2 should f Health and Men item 27 is marke other treumetic		JEANETTE BEV	ERAGE (SISTER	2608	W. PATAR	SCO AVE.		REMD 2123
3altimore,	Pages 1 nent of H nt: If ite: ry or oth		20a. Method of Disposition 1. Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Disposition (cemetery, crematory	or other place)		Oc. Location - City or To	100
Him		1 8	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		OODLAWN 22. Name			BALTIMORE	
Ba	permit. Departrimporte eny inju		Dietich	N. Willia	n JO2	EAH FULTO		R. FUNERI BALTO, MO	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not enter the r	node of dying, such as cardia			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		olar Hemo	rahage duet	o Pancy	topenía 1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	Deficiency		100	years
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec		vericiney	397410	777	
	nd Adams	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c					
60,	cate be executed shysician and the burial-transit		resulting in death) Last	Due to (or as a consec	quence of):				
68760	physics the b	dical		d					
Box (eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn.				23d. Date of delive	rv
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live birth 2 ☐Feta 4☐Pregnant at time of c 9☐ Unknown		(specify)			Day Year
P.0	that the		Part II. Other significant conditions	ontributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did tob	acco use contribute to th	e cause of death?
Vital Records,	quires tha in signed uld be de	Completed by	Cryptococca	A			1 □ Ye		
900	iaw requir as been si 2 should I	piet					24a. Was an		sy findings available
Ä	The Tate he	Com					autopsy perform	ed? death?	opletion of cause of 2 □ No
Vita	ician: T certificat ector, pa	Be	25. Was case referred to medical examiner?	Hospital:	111/22	T -	ath (Check only one	,	
	Phys r this ral dir	2	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 2	ER/Outpatient 3 28b. Time of		Home 5 ☐ Resider	nce 6 Other (Specify)
ion	nding lath. r: After e funer	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. 20001100 1101	williary occurred	
Division of	i or Attendi after death. Director: A i in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, street, fac fy)	tory, office	28f. Location (Str. City or Town,	eet and Number or Rural State)	Route Number.
_	To the Hospitei or Attending Physician: within 24 hours atter death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medicai C	29a. Certifier 12 Certifying Pt	ysician: To the best of my kno	owledge, death occur ation and/or investigat	ed at the time, date and plac- ion, in my opinion, death occ	a, and due to the caurred at the time, da	use(s) and manner as sta le and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner stated.		29c. License number		d. Date signed (Month, L	
	->-0		Della (Beyzaha		P06062	17	~ ~	
	1	N	30. Name and address of person who	complet * cause of death (Iter	π 23a) (Type, Print)				
	5		CHAMPA ABET 31. Date filed (Month, Day, Year)	SINGHE, M.D.	900 C	ATON AVEN	4 E BALT	IMOKEN	10 21229
	Sta Registr		MAY 3 1 20	106 Marie A	y Goods	•			

BEVERAGE, MAURICE

		For State Registrar	State of Marylar	•		of Health and of Death		Reg. No. 2	006	1692
Physicia /Medic	al	Decedent's Name (First, Middle, Last) Amy L Bo Bo As Facility Name (If not institution, give s	olick		4b. City. To	wn, or Location of De	2. Date of the Month May	26, 2	Yeer 006 ounty of Death	3. Time of Death 2:03 P
Examin Funeral Director		Baltimore Washingt 5. Social Security Number 6. Sex 218-78-9121	on Medical C		G1 e	n Burnie	rs. 8. Date of l	An	ne Arui	ndel lace (State or Fore try) cyland
28a-f ehow notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Aru 10e. Street and Number		ty, Town or Lo	n Burni			10g. Citizer	n of What Cour	0d. tnside City Limi 1 ☐ Yes 2€ h
"netural", or items 23s or 28s-f show idical Exacting trust be notified at	by Funeral	93 Mary Lane #101 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 [] Yes 2 [] No If Yes, Give Year or Dates:	J.S. 13.	Was Deceden If Yes, specify 1 ☐ Yes 2 ☐	21061 t of Hispanic Origin? Cuban, Mexican, Put No Specify:	(Specify Yes or lento Rican, etc.)	No- 14.	ted Sta Race - Americ Black, White, pecify:	an Indian,
jene. r then "ne tre Medic	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) Coltege (1-4or 5+) 1yr	(Give	DO NOT use i	one during most of w	rorking		of Business/Ind	,
and Mental Hygi is marked other aumatic event, t	To Be (17. Father's Name (First, Middle, Last) Robert Carl 19a. Informant's Name/Relationship (Ty)	Reed	19b. Maili	ng Address (S		ame (First, Midd tance Rural Route Nun	Franc	es l	Day Code)
of Health		David P. Bolick/htt 20a. Method of Disposition 1 Burial 2 **Cremation 3 BR	emoval from State	Place of Disponentery, cre	osition (Name matory or othe	of r place)	len Bur	20c. Local	tion - City or To	wn, State
Department Importent: any injury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		D 2	2. Name and A	ematory 5/ odress of Facility on Funeral napolis Ro	Home &	Cremat	nton, Ma cory, P Maryland	. A .
hysician and hysician and price price price in price p	dical Examiner	23a. Part Lanter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	tury gueno of us call guerice of):	failur 2 ar 2	we what as card	lac or respiratory	arrest,	, A	Approximate Interval Batween Onset and Death O
by the attending phy tached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	3c. tf yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	aldeath 3	⊒Ectopic pregi ⊒ Other (speci			230	d. Date ot delive Month	ory Day Year
ate has been signed page 2 should be de	Completed by Pt	Part II. Other significant conditions con		sulting in the u	underlying caus	se given in Part I.	- 1{ 24a. W	Yes 2 1	No 3∏Prob 24b. Were auto	ne cause of death? ably 4 Dunkno psy findings availa mpletion of cause 2 No
this certificate	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	fospital:	Outpatie	nt 3 DOA	Other	eath <i>(Check on)</i> Home 5 ☐ Re		Other (Specif	ùl.
After	Certification: T	27. Manner Death 1 ** atural 5 Pending investigation 2 Accident investigation 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of tnjury	of 28c	Injury at Work? 1 Pes 2 No	28d. Describ	e how injury o	occurred	·
within 24 hours after death To the Funeral Director: completely filled in by the	Medical CertIfi	4 Homicide determined 29a. Certifier 12 Aartifying Physicheck only 2 Medical Examin	28e. Place of Injury - At h building, etc. (Speci elcien: To the basis of examina ner: On the basis of examina	fy) bwiedge, daa	th occurred at t	he tima, date and pla	City or 1	own, State)	nd manner as st	
within 2 To the	Med	29b. Signature and title of certifier	and manner stated.	m 23a) (Type	1	icense number	-/-	29d. Date s	signed (Month,	Day, Year) -2006
Sta Registr		30 Name and address of person who convent of the state of	empleted cause of death (Ite.	pme	Print) Och	e fol him	. thicun	1 M	0210	90

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) 6 Certificate of Death

			For Stata Registrar	State of Ma		tificate of Dea			3. No.	16928
	Physicia	an	1. Decedent's Name (First, Middle, Last)	.) .				2. Date of Death Month	Day Year	3. Time of Death 7:00A M
	/Medic	al	4a. Facility Name (If not institution, give		\	4b. City, Town, or Loca	ation of Death	5	27 2006 4c. County of Death	1.007
	Examin	er	Manor Care Pot			Potomac			Montgon	nery
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday) Q3 Yrs.		Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Birthr	place (State or Foreign
	Director		Usual Residence of Decedent		70			3-22-1	1913 Ron	ania
	iryland show	_	10a. State 10b. County		10c. City, Town or Lo					0d. Inside City Limits 1 Xes 2 □ No
	the Ma	ecto	mb Mont-go	mery	Potoma	10f. Zip Code		100	g. Citizen of What Cou	
	3a or	I Dir	10714 Potomac Te	nnis La	ne.	20854			ISA	,
	ems 2	Funeral Director		12. Was Decedent 8	ever in U.S. 13.	Was Decedent of Hispan f Yes, specify Cuban, Me	nic Origin? (Specestican, Puerto F		14. Race - Americ Black, White,	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "neturel", or Items 23a or 28a-f show event. The Medical Esaning must be radified at	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 N If Yes, Give Year or Dates:	lo		ecify:		Specify: (N)	rite
9-0	2 hour	ted	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	tent's Usual Occupation	n most of workin	g 16	Sb. Kind of Business/In	dustry
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d 2,	filed with Hygiene. other than		17. Father's Name (First, Middle, Last)	5+	Titel		Mother's Name	(First, Middle, Ma	Kadio aiden Sumame)	
/lan	2 should be filed within and Mental Hygiene. is marked other than eumatic event. Its Ms	To Be	Petre Burilia	nu		(Inkno	MM		
Maryland 21215-0036	S a s		19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street and N LS+,SWA)			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20024
	of Health item 27 other tr		Serban Desliu/A	riend	20b. Place of Dispo	sition (Name of natory or other place)			oc. location - City or To	
E O	Pages nent of nnt: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Chesareal	ce Cremator	June	21,86 8	Beltsville	am.
Baltimore,	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Licens	98	22	2. Name and Address of	Facility Kow	2	+ cren	ation
	20389		23a. Part 1. Enter the disease, or compl	ications that caused	the death. Do not ent				D50010	Approximate
E	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each lir Sepsis	16.				2	Interval Between Onset and Death Weeks
	/Medical Examiner		resulting in death)		a consequence of):					WCCICO
	Examine	7	Sequentially list conditions,	Advanced	Dementia					
1	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Atherosc						
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68760,	tificate be executed ig physician and as the burial-transit	edlcal		d						
Box (eath certif attending for use a:	-	236. was decedent pregnant	3c. If yes, outcome		Ectopic pregnancy			23d. Date of delive	•
	e deat the att	Physiclan//	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at 9☐ Unknown		Other (specify)			Month	Day Year
P.0	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	/ Ph	Part II. Dther significant conditions co	ntributing to death b	ut not resulting in the u	nderlying cause given in	Part J.	23e. Did toba	acco use contribute to t	he cause of death?
Records,	quires in sign uld be	ed by						1 🗀 Yes	2 □ No 3 Prot	pably 4 Unknown
eco	e law requir has been si je 2 should	Completed						24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
al R		Соп							VNo 1 □ Yes	2 No
Vital	Physicien: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatier	Other	1	(Check only one) ne 5 ☐ Residen	ice 6 □Other (Specia	
J Of	ding Phy h. After this funeral c		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da				8d. Describe how		,,
siol	Attending ir death. ector: Afte by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be			M 1 Tyes		8f Location (Stre	eet and Number or Rura	Al Poute Number
Division	or Attendated after death	ertifl	4 Homicide determined	building, et	ury - At home, farm, str c. (Specify)	eet, ractory, office	-	City or Town,	State)	ar moute reamber,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:	29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge, deat	h occurred at the time, divestigation, in my opinion	ate and place, a	nd due to the cau	use(s) and manner as s	tated.
	the H thin 24 the Fi	Medic	29b. Signature and title of certifier	and manner sta		29c. License nur			d. Date signed (Month,	
	To Cor		Soul Signature and time of certifier	MM.		D3131		2	5/20/06	/
	10		30. Name and address of person who o		eath (Item 23a) (Type,	Print)			130100	
	1,			8 Wiscons	in Ave. Be.	thesda, M	D 2081	4		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Hegistr	ar's Signature					

			For Stete Registrar	State of Maryland		artment of H			giene Reg. No.	2006	16	929
			Decedent's Name (First, Middle, Las	(1)			-	2. Date of De Month	ath Day	Year	3. Time of	Death
	Physicia		Minnie E. B	lake						006	8:30	a ^M
No. of Contract of	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	th	4c. (County of Death		
ı			37 Owensville	Road		West R				ne Aru		
	Funeral		Social Security Number 6. So	CM 250C		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	y, Year)	Cou		
	Director		218-32-8149	95	Yrs.			Sept.	2 19	910 Vir	ginia	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside Cit	ty Limits
	daryli f sho	5	36 3 3	wand of Mo	a+ D4	****					1 🔯 Yes	2 🗌 No
	the 28a-	Directo	Maryland Anne A	runder we	st Ri	10f. Zip Code			10g. Citiz	en of What Cou	ntry?	
	3a or		37 Owensville	Poad		2077	18			US	: A	
	Jeath Tre 2:	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	i. 13. \	Was Decedent of H	ispanic Origin? (Specify Yes or No	- 1	4. Race - Ameri	can Indian,	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinational bandilled at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		fYes, specify Cuba 1□Yes 2⊠ No	Specify:	no Hican, etc.)		Black, White, Specify: B1	ack	
5-0036	72 hou natura	Completed I	15. Decedent's Ed (Specify only highest gra	lucation	(Give	dent's Usual Decup	during most of we	orking	16b. Kin	d of Business/Ir	dustry	
2	thin 7	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)	9				
2121	filed wi Hygien Sther th	Con	6th	0		Dome	stic			vqte E	amily	
2	d oth	Be	17. Father's Name (First, Middle, Last)					me (First, Middle		Sumame)		
<u> </u>	Meni Meni arke	ပ္	Luther Harri					nie Goo				
Maryland	2 should be to and Mental to is marked of raumatic even		19a. Informant's Name/Relationship (AC 20		ng Address (Street						
	1 and Health em 27 ther tr		Joyce Phillips	(Daughter)		06 Fox F	Iound C	t. Seve		Md. 21		
5			20a. Method of Disposition	ce	metery cres	natory or other place. M. Chur	-ch					
≣	tment: tant:		4 □Donation 5 □ Other (Specify	//lCem	etery	T	5/2	6/06	OWe	ensvill	e, Md	
Baltimore,	permit. Pages 1 a Depertment of Hea Important: if item any injury or otha		21. Signature of Funeral Service Licer	Perse MOV8	_	Name and Addre Vm. Rees 321 West		ns MOrt	uary	16. P.A.	01	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	. Do not ent					50.561 100.0	Approximate Interval Bets	ween
, .	Physician		Immediate Cause (Final disease or condition	Sensio							Onset and D	
Fig.	/Medical	Ι.	resulting in death)	Due to (or as a consequ	ence of):							
	Examiner		Sequentially list conditions	b								
	D =	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):							
6	acute ind trans	am	Cause (Disease or injury that initiated events resulting in death) Last	c.								
8760,	e exe tien a	Ical Examiner	resulting in death) cast	Due to (or as a consequ	ence or):							
876	cate be executed obysicien and the burial-transit			d						-		
9 ×	ertifica ding ph se as t	/Me	IF FEMALE:	23c. If yes, outcome of pregnar	acv					12d Data of dala		
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal	death 3[Ectopic pregnancy Other (specify)	1			3d. Date of deliv Month		Year
-	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be deteched for use as the burial-transit	Physician/Med	1 □ Yes 2 ⊠No 9 □ Unknown	9□ Unknown	au J	_ Other (specify) _						
<u>Р</u>	that t ed by detec		Part II. Other significant conditions of	ontributing to death but not resu	Iting in the u	nderlying cause giv	ren in Part I.	23e. Did	obacco u	se contribute to	he cause of d	leath?
Division of Vital Records,	uires tha signed Id be det	d by	Peripheral Vas	Peripheral Vascular Disease, Diabetes						Tes 2 No 3 Probably 4 Unknown		
Š	v requir been si should	ete	Rhematord a	atthe oil to	,			24a. Was	an	24b. Were aut	opsy findinas :	available
Re	The lav	Completed	Thumas 197 a de	1 (11111V)				auto perfe	psy ormed?	prior to co death?	impletion of c	ause of
a		e Co	25. Was case referred to medical				26 Place of D	1 ☐ Yes eath (Check only	2 No	1 🗆 Yes	2LI No	
₹	sicia cert	100	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatie	nt 3 DOA Oth	er	Home 5 Resi		Other (Speci	fv)	
ō	Phys arthis aral di	٦. ت	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Injur	y at	28d. Describe			.,,	
on	th. : Afte	i i	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injury	Wo M 1□	Yes 2 □ No					
Sis	Attend r death ector: / by the f	100	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of injury - At no		reet, factory, office		281. Location (City or To		d Number or Run	al Route Num	ber,
á	s afte	Certification;	4 Holficide	building, etc. (Specify	,			0.07 0.7 10	····, Otato,			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certificacompletely filled in by the funeral director.	Medical (29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exel	nysicien: To the best of my know miner: On the basis of examinat and manner stated.	wledge, deat ion and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s	r)
	within 2 To the complet	Me	29b. Signature and title of certifier	0		29c. Licens			29d. Date	e signed (Month	Day, Year)	A
			1 Nayne 1	2 William	m	D3	8263		Man	25,200	۷.	
	(1)		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Drint)			0			
	V		Wayne A	Bierbaum 1	34 0	neusvill	e Kel,	West	Mil	ver, n	1 \$)	
10	St	ate	31. Date liled (Month, Day, Year)	32. Registrar's Signar	IIIre					,		
	Regist	rar	MAY 3 1 2006	Bus !	ADBA!	9						
- 01	JAN 17 Dov 1/	2001										

06-03619		Please Type or Print in Black Indelible link								
Donye Blakston		State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2.0.0.5	1000							
		Registrar Reg No. 2000	ime of Death							
Physicia Medical Examin		Month Day Year	653 hrs							
- con		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death								
		223 S. Broadway Baltimore								
Funeral Director	1	5. Sand equity Naviou 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9 Birthplace 1 Amonths Days Hours Min March 1 984 Foreign Country	State or Maryland							
_		Usual Residence of Decedent 10a State 10b. County 10c City, Town or Location 10d.	Insigle City Limits							
and show any nce.	or	Manda A MA	Yes 2 No							
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 2875 Pelham Ave. 10f. Zip Code 21213 10g. Citizen of What Country?								
h with ms 23.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American II If Yes, specify Cuban Mexican, Puerto Rican, etc.) White, etc.	ndian, Black,							
ifter death	by Fun	S vidowed or Dales:								
hours a	ed b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired)	try							
n 7.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Whereployed MA								
215-0 be filed water Hygic real Hygic sert, the M	Be Co									
ore, MD 21215-003 ss 1 and 2 should be filed within of Health and Mental Hygiene If item 27 is marked other it her traumatic event, the Med	To	19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip.	Gode) 12/2/-							
imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mental 1 naut: If item 27 is marked or other traumatic event,		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. 20c. Location - City or Town 20c. Location - City o	Marylane							
Baltimore, pernit Pages I ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify: 21. Signature of Facility Parker Fune and Address of Facility Parker Fune all Home 22. Name and Address of Facility Parker Fune all Home 23. The state of Facility Parker Fune all Home 24. The state of Facility Parker Fune all Home 25. The state of Facility Parker Fune all Home 26. The state of Facility Parker Fune all Home 27. The state of Facility Parker Fune all Home 28. The state of Facility Parker Fune all Home 29. Th	A. 2122							
Physician			proximate Interva							
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot wounds of chest and right arm	etween Onset and Death							
Examiner	l	or condition resulting in death) Due to (or as a consequence of):								
	<u>.</u>	Sequentially list conditions, b. f any, leading to immediate Due to (or as a consequence of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated								
executed an and al - transit										
al al	dica	UNPENDED ★ AMENDED 5 per fh g856 6-5-06 vt								
Division of Vital Records, P.O. Box 68760, rothe Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	Year							
b. Be the de by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the conditions.	ause of death?							
s, P.O. irres that the signed by a detached	ģ		4 Unknown							
ords, w requir is been s should 1	Completed	24a Was an 24b Were autopsy autopsy prior to comp	y findings available							
tal Records ciau: The law requi certificate has been ector, page 2 should	d m	performed? death?	2 No							
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Vita hysicia this ce	o Be		ene							
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the fact death and the ral birector: After this certificate has been signed by led in by the funeral director, page 2 should be detact	n: T	27 Manner of Death 28a Date of Injury 28b, Time of Injury 28c, Injury at Work? 28d, Describe how injury occurred								
trendi death y the f	atio	The second secon	- (- N h Ot							
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural R or Town, State) 3 Suicide determined deter	oute Number, City							
ospita hours uneral y fille										
To the Hos within 24 h To the Fur	Medical	(Check only one) Check only one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one)	use(s)							
To To	Med	and manner stated 29b. Signature and title of certifier 29d Date signed (Month, I	Day, Year)							
		O.C.M.E. May 28, 2006								
		30. Name and address of person who completed cause of death (Item 23a)								
7		Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201								
	tate									
Regis		- IIII & Z 2000								
DHMH 17 Rev 1/ OCME 2006	/2001	ORIGINAL								

			1 - For State of Maryla		artment of H			Reg. No.	6 16931
	Physicia /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Rida Simon Brown				2. Date of De Month May		3. Time of Death 3:45a
	Examin		4a. Facility Name (If not institution, give street and number) Morningside House of Ellicott		4b. City, Town, or Ellicot	t City		4c. County of I	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In y 215-10-5191 1 M 2 1 M 89	rs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min		ly, rear)	Birthplace (State or Foreign Country)
	I within 72 hours after death with the Maryland jeloe. then "natural, or liems 28a or 28a-1 show the holical Exprinted or mail the holical Exprinted or mail to be collified at	or	10a. State 10b. County 10c.	City, Town or Lo ayton	ocation				10d. Inside City Limits 1 ☐ Yes 2 🖫 No
		I Director	10e. Street and Number 4762 Linthicum Road		10f. Zip Code 21036			10g. Citizen of Wha	at Country?
36		by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ın, Mexican, Pue	Specify Yes or No rto Rican, etc.)		American Indian, White, etc. hite
Maryland 21215-0036		Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16b. Kind of Busin					
land 2	be filed stal Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last) Walter A. Simon	- 1		Julia A	. Davis	, Maiden Sumame)	
	nd 2 shulth and 27 ls m		19a. Informant's Name/Relationship (Type, Print) Carol L. Brown (daughter)		ng Address (Street Linthicu			er, City or Town, Sta ID 21036	ite, Zip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 I any injury or other tra once.			b. Place of Dispo cemetery, crer rest Law	osition (Name of matory or other place yn Memoria	a1 5-3	1-06	20c. Location - Cit Marriotts	
Balti			21. Signature of Funeral Service Licensee Page Haught Hubert		2. Name and Addre			eral Home Md 21784	& Chapel
8760,	law requires that the death certificate be executed as been signed by the attending physician and as been signed by the attending physician and as been signed for use as the burial-transit	lical Examiner	23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conduct of the condition of the con	sequence of):	can ce		ас от гезрпасоту а	11031,	Approximate Interval Between Onset and Death SYEARS
P.O. Box 6		nyslcian/Med	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	_Ectopic pregnancy	,		23d. Date of Month
	w requires that the state of speed by should be detact		Part II. Other significant conditions contributing to death but not Congestive heart for	resulting in the u		en in Part I.			ite to the cause of death? ☐ Probably 4 ☐ Unknown
I Records,	The law requate has beer page 2 shou	Completed by					24a. Was auto perfo 1 Yes	psy prio ormed2 dea	re autopsy findings available r to completion of cause of th? Yes 2 \(\subseteq \) No
of Vital	Physician: The this certificate ral director, pag	To Be		2 ER/Outpatier		er: 4 Nursing	Home 5 Resi	idence 6 ther	Specify) TVINE
Division o	fune fune	Certification;	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Yea) 28a. Date of Injury (Month, Day Yea) 28b. Place of Injury (Month, Day Yea) 28b. Place of Injury (Month, Day Yea)		M 1	y at k? Yes 2 □ No	28f. Location (how injury occurred (Street and Number own, State)	or Rural Route Number,
Ď	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, deat	th occurred at the til	ne, date and plac	ce, and due to the	cause(s) and mann	er as stated.
	To the Hospital within 24 hours of To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated. 29b. Signature and title of certifier		29c. Licens		curred at the time,	29d. Date signed (M	
	./			SICIAN (Item 23a) (Type	-	53590		MAY 2	9,2006
	5		30. Name and address of person who completed cause of death SYDKM DY MD 12M 60	9		TMORE	MO	21090	
	Sta Regist	ate rar	31. Date filed (Nonth, Day, Year) Registrar's S	ignature A	W				

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

faryland

216-68-5755

Usual Residence of Decedent

MICHAEL A. BARKSDALE SR.

General

1∏M 2□ F

48

4a. Facility Name (If not institution, give street and number)

	bor une ly fi	S	29a. Certifier (Check only 2	1 Certifying Pl	nysician: To the best of	of my knowledge	e, death occume	ed at the time, date	e and place, and due to the	ne cause(s) and manner a	s stated.		
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Cer	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
Division		Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury - At home, larm, street, factory, office 28f. Loc				28f. Location City or 1	Location (Street and Number or Rural Route Number, City or Town, State)			
ion c	E E	tion; To B			27. Manner of Death 1 ☐ Natural 2 ☐ Accident	5 ☐ Pending investigatio	28a. Date of Injur (Month, Day	Year) 28b.	Time of njury M	28c. Injury at Work? 1 ☐ Yes 2		e how injury occurred	
of Vi	Physicia r this certi rral directo		examiner?		Hospital: 1 Purpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Hom					sidence 6 Other (Spe	ecify)		
ital	: <u>j</u>	0	25. Was case referre	ed to medical				26. P	lace of Death (Check onl				
Re	an: The law tificete has l	ошо						· · · · · · · · · · · · · · · · · · ·	au pe	rformed? 🕒 death?	utopsy findings available completion of cause of		
Records,	w require been si should t	Completed							24a. W	Yes 2 No 3 P			
α	res thet th igned by be detact	۵	Part II. Other signific	cant conditions	contributing to death bu	ut not resulting i	n the underlying	g cause given in P		d tobacco use contribute t			
.O. Box	Manage of the stat	Physician/Medical	23b. Was decedent point the past 12 mm 1 Tes 2 Tes 2 Tes 12 mm 9 Tes 2 Tes 12 T	nonths?	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic 5 □ Other (23d. Date of de Month	Day Year		
x 68760,		/Medic	IF FEMALE:		d	of pregnancy				23d Date of de	livery		
,09		al Examiner	resulting in death) Last Due to (or as a consequence of):										
		iner	Sequentially list condition if any, leading to immicause. Enter Underly Cause (Disease or in	ditions, mediate lying	Due to (or as a consequence or):								
1			Immediate Cause (Final disease or condition resulting in death) a. Metastatic Pharyngea Tongue Squamous Cell Cancer Due to (or as a consequence of): b. Metastatic Pharyngea Tongue Squamous Cell Cancer Due to (or as a consequence of):										
	Physician		shock, or heart Immediate Cause (F	failure. List only Final	one cause on each lin	θ.					Interval Between		
8	88 = 8	,	23a Part Foter the	a disease or com	olications that caused	the death. Do			MONROE ST. B		ARYLAND 21217 Approximate		
altir	permit. Page Department of Important: If eny injury or ance.	1							acility PHILLIPS	BALTIMORE, FUNERAL HOM	E, P.A.		
Baltimore,			1 Burial 2 Z		Removal from State	cemete	ny, crematory of ON CEM	r other place)					
	of Heelth Item 27 other tr		NANNY W 20a. Method of Dispo	ILLIAMS ((SISTER)	20b. Place o	1346 N Disposition (A	the state of the second	ON ST. BALTI	MORE, MARYL			
lary	s 1 and 2 should f Heelth and Men Item 27 ie marke other traumatic	F	19a. Informant's Nan	ne/Relationship (Туре, Print)	19b	. Mailing Addre	ss (Street and Nu	mber or Rural Route Nun	nber, City or Town, State,	Zip Code)		
Maryland	buld be fil Mental H arked ott atic even	To Be	17. Father's Name (F JOHN W.)				other's Name <i>(First, Midd</i> LILLIE BARKS				
212	s should be filed within and Mental Hygiene. Ie marked other then "i aumatic event, the Mac	Completed by	Elementary/Second		College (1-4or 5-	+) F	HOME IM	PROVEMENT		CONSTRUC	TION		
15-0	c	ojete	(Specify	15. Decedent's Ed y only highest gra	ide completed)		Decedent's Us (Give kind of s life. DO NOT	sual Occupation work done during r 'use retired)	πost of working	16b. Kind of Business	VIndustry		
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. I set Hygiene. I set the "Madical Exam" her must be notified at event, the Madical Exam" her must be notified at		1 Never Married 3 Widowed 4	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo		Yes 2 No Specify:		Specify: BLACK				
	oms 23	Funeral Director	11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Dec	edent of Hispanic	Origin? (Specify Yes or I	No- 14. Race - Am Black, Whi			
	with the a or 2	Dire	10e. Street and Number 10f. Zip Code 21217							10g. Citizen of What Country? USA			
	88-1 e	ctor	MD.	N/A		BALTI					1 √ Yes 2 No		
	Pla Po Po		10a. State	10b. County		10c. City, Tow	n or Location				10d. Inside City Limits		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

Foltimore, Mi If Under 1 Year If Under 24 Hrs. Months Days Hours Min.

Reg. No.

Year

, 2006

N/A

4c. County of Death

1538 PM

9. Birthplace (State or Foreign

MARYLAND

2. Date of Death Month

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State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yeer **Physician** May 30 2006 7:30A PAUL BEACH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 19 Oak Hampton Drive Timonium Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | September 15, 1931 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**XX**M 2□F 74 Maryland 212-28-1584 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Timonium Directo Maryland Baltimore 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number or Itams 23a or 21093 19 Oak Hampton Drive USA death \ Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married filed within 72 hours after 1 ☐ Yes 2XXNo Specify: Baltimore, Maryland 21215-0036 White Specify: þ 3 Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Bay Pilot Pilots Assoc of MD 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If Item 27 Is marked ofth any injury or other trsumatic event, once. 17. Father's Name (First, Middle, Last) Be Paul Beach Sr Velma Hidev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anne Seifert Beach Wife 19 Oak Hampton Drive Timonium Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GreenMount Crematory 5/31/06 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 21. Signature of Funeral prv/ce Licensee nas 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung Carcinoma 15 Months Friysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? jo 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2**X X**No 1 Yes 1 ☐ Yes or Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home SXX Residence 6 Other (Specify) 1 ☐ Yes 2XXNo Medical Certification: To 3FT DOA 27. Manner of Death 1 Watural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division Injury 5 Pending s after dec. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a 1 XCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the ! 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier D0033624 5/30/06 completed cause of death (Item 23a) (Type, Print) John C Downs 7505 Osler Drive Suite 302 Towson, Maryland 21204 32. egistrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 3 1 2006

		•	For State Registrar	State of M	larylan	d / Dep <i>Ce</i>	artment of Hertificate of D	ealth and Death		giene) (16	16934
3	5. S.		Decedent's Name (First, Middle,	Last)					2. Date of De	ath	V-5-5	3. Time of Death
	Physicia /Medic		James Andrew Bar	rett III					Month	22	2006	6:17 PM
	Examin		4a. Facility Name (If not institution,				4b. City, Town, or	Location of Dea	ath	4c. County		
			Manorcare Health				Towson If Under 1 Year	If Under 24 Hi	rs. 8. Date of Bir		timo	
	Funeral Director		5. Social Security Number 219–26–6539	5. Sex 7. A 1 M 2 □ F	9e (in yrs 66	last birthday Yrs.	Months Days	Hours Mi		y, Year)	Cour	place (State or Foreign ntry) nsylvania
4,940	D		Usual Residence of Decedent						IIGECII	, 10		
	anylan show d at	_	10a. State 10b. County Maryland Baltim	oro		y, Town or L Ckeysv					1	1 ☐ Yes 2 🛣 No
	he Mi	Director	10e. Street and Number	OLE	000		10f. Zip Code			10g. Citizen of V	What Cour	
	with with the same	Dir	329 Lord Byron L	ane. Apt. 1	202		21030			United		
	death ma 23	Funeral	11. Marital Status	12. Was Decedent	t Ever in U.	S. 13.	Was Decedent of His	spanic Origin?	(Specify Yes or No	- 14. Rac	e - Americ	can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be maified at ADGE.	by Fur	1 ☐ Never Married 2 XX Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces d 1 ☐ Yes 2 X If Yes, Give Year or Dates:	No		If Yes, specify Cubar 1 ☐ Yes 2 No	Specify:	erto Rican, etc.)	Specify	k, White, wh	etc. nite
Ö	2 hou		15. Decedent's (Specify only highest			16a. Dece	edent's Usual Occupa	ition	ordking.	16b. Kind of Bu	ısıness/ln	dustry
215	ithin 7 ne. nen "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired)		orking			
2	lled w lygier her th		17. Father's Name (First, Middle, La	act)		machi	ne operate		ame (First, Middle,	constr		on
Maryland 21215-0036	ld be fi ental h ked ot ic ever	To Be	James Andrew Bar						McClure	Walder Suman	10)	
ary	shou and M s mar	-	19a. Informant's Name/Relationshi	p (Type, Print)		1	ing Address (Street a					
	and 2 ealth a n 27 i		Dorothy Barrett/	wife		_		n Lane,				le,MD 2103
ore	ges 1 t of Hi if iter or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	3 □Removal from State	• 0	emetery, cre	osition (Name of ematory or other place	· I	Date	20c. Location -		
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Ba	Depar Impoi any ir		> Gold O. Mil	tchell			22. Name and Addres. Mitche. 6500 Yo	ll-Wied ork Rd.	efeld Fur. Baltir	neral Ho nore, MD	me 21	Inc. 212
+ *			23a. Fart1. Enter the disease, or connect, or heart failure. List of	omplications that cause nly one cause on each	d the deat line.	n. Do not er	nter the mode of dying	g, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)				lisease (R	enal fa	ilure)			Onsot and Boath
	/Medical Examiner		rossiting in assitiny	Due to (or a			Mellitus					
		er	Sequentially list conditions, if any, leading to immediate	b. Type 2 Due to (or a			letittus		· · · · ·			
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.								
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× 6	The law requires that the death certificate hes been signed by the attending tagge 2 should be deteched for use es	0 1	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom						23d. Dat	ol delive	erv
B	death e atter d for u	Physician/M	in the past 12 months?	1☐Live birth 4☐Pregnant			□Ectopic pregnancy □ Other (s <i>pecify)</i>				nth	Day Year
O.	by the	hys	9 Unknown	9□ Unknown								
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ord	requir seen s hould	eted	Nephrotic syndro	ше								pably 4 NUnknown
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a		e Co	25. Was case referred to medical					Of Diago of D	1 ☐ Yes	2 X №	Yes	2□ No
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_	Hospital 24 hours a Funeral letely filled		29a. Certifier 1X Certifying	Physicien: To the bes	t of my kno	wledge, dea	th occurred at the tim	e, date and pla	ce, and due to the	cause(s) and ma	nner as s	tated.
	To the Hospital or Attending i within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical		xaminer: On the basis and manner s	of examina	tion and/or i	nvestigation, in my op	inion, death oc	curred at the time,	date and place,	and due to	o the cause(s)
	To the within 2 To the complet	×	29b. Signature and title of certifier		0		29c. License			29d. Date signed		
,			Kathere	mas	pde	100	H00549	70		May 25,	200	р
	6		30. Name and address of person w Katherine Asadi	DO. 20 E	. Time	onium	Rd., Suite	e 209	Timonium	n, MD 2	1093	
	- Sta Regist		31. Date liled (Month, Day, Year) MAY 3 1		trar's Signa		heele					
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6-03498			Please Typ										
vonne Margare		1- For State	e of Maryland /	Departmen Certificate			and N	/lental Hy		g No	200	6 169	3
Physici Medical Exam	an/	Registrar 1. Decedent's Name (First, Middle, La Yvonne Margaret						2	Date of Death Month May 23, 20	h Dav	Year	3 Time of Death 1330 hrs	
some of		4a. Facility Name (if not institution, g 7846 Woodside Terrace,	ive street and number)	-		. City, Tow Glen Bu		ation of Death			County of Dea		
Funeral Director			Sex 7. Age M 2 F	(In yrs. last birthda	y) Yrs	If Under 1 Months	\rightarrow	f Under 24Hrs. Hours Min.	8. Date of Birt March 2		Fore	irthplace (State or ign ^{ountry)} Marylan	n d
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th the Maryland 23a or 28a-f show notified at once.	Director	Mary1and Anne Anne Anne Anne Anne Anne Anne An		Glen Bur		10f. Zıp Co					zen of What Co	untry?	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene III. If item 27 is marked other than "natural", or items 23a or 28a-f shin mit. If item 20	Funeral [7846 Woodside Te 11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent E Armed Forces?	. 204 Ever in U.S. 13	If Yes	, specify C	of Hispan Suban, Me	ic Origin? (Spe exican, Puerto R	cify Yes or No-		White, etc.	rican Indian, Black,	
"natural", (Examiner)	ğ	3 Widowed 4 X Divorce 15. Decedent's Education (Specify	only highest grade comp	dur	cedent's		cupation (Give kind of wo			Specify. WI	lite JIndustry	_
5-0036 iled within 72 l Hygiene 1 other than " the Medical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+		nema	ker_	10 1	Nother's Name (Firet Middle N	Asiden		Home	
D 21215-003 should be filed withing and Mental Hygiene 7 is marked other the natic event, the Meg	Be	17. Father's Name (First, Middle, Last James F. Klinger 19a Informant's Name/Relationship	nsmith	10b N	Apilina /	Addrass /	Ja	ane W. 1	rench		ity or Town, Sta	te Zin Code)	
ore, MD 2121 s 1 and 2 should be fi of Health and Mental 1 If item 27 is marked her traumatic event,	Το	Sarah Klingensmit		14	909	Nashı	ıa La	ane Bo	owie, M	D	20716 Location - City of		_
Baltimore, MD 2121: permit Pages I and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event.		1 X Burial 2 Cremation 3 4 Donation 5 Other Speci		new Fer	or othe	r place) od –Ce	mete	May 200	30, 6	Kir	naston.		
Baltimo permit Pag Department Important:		21. Signature of Funeral Service Lice	_	1	42	1 Cra	ain F	Hwy. S.H	E. Gle	n B	e, P.A. urnie,		
Physician /Medical Examiner	p) (3		each line. a. Cardiac Arrh	nythmia	nter the	mode of a	iying, suc	n as cardiac or	respiratory arre	est, sno	ock, or neart	Approximate Inter Between Onset a Death	
	<u>.</u>	or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a consect to Cardi megaly Due to (or as a consect to consect t	associated	wit	h left	venti	ricular h	ypertropl	hy		1	
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Division of Vital Records, P.O. Box 68760, talor Attending Physician: The law requires that the death certificate be executed as after death all Directors. After this certificate has been signed by the attending physician and led in by the fineral director, page 2 should be deached for use as the burial - transit	ysician/Medical	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknow		e of pregnancy 2 ime of death 5		l death er (Specify		Ectopic pregnar	су	230	d. Date of delive Month	pry Day Year	
cords, P.O. Belaw requires that the dehan been signed by the 2 should be detached f	d by Phys	Part II. Other significant condition	s contributing to death	but not resulting in	the un	derlying ca	ause giver	n ın Part I.	23e. Did to			o the cause of death?	
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on of lending Pl sath or: After the funeral	ation: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investig		ry 28b. Tim	ne of Inj	´	c. Injury a	t Work?	28d Describe h	now Inju	ury occurred		
Division of Vital Rec Hospital or Attending Physician: The 124 hours after death Funeral Director: After this certificate I elev filled in by the funeral director, page	Certification:	2 Accident Investig 3 Suicide 6 Could n 4 Homicide	ot be 28e. Place of Inju	ury - At home, farm	n, street	, factory, o	ffice build	ling, etc.	28f. Location (\$ or Town, S		and Number or F	Rural Route Number, 0	lity
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledical C	29a. Certifier 1 Certifying Phys	sician: To the best of my ner:On the basis of exam and manner stated	knowledge, death	occurre	ed at the tir on, in my o	me, date a	and place, and ceath occurred at	due to the caus	se(s) an	nd manner as sta ace, and due to	arted the cause(s)	
Veriting 170	1 9	20b. Signature and title of certifier	/			29c I	icense ni	umber		29d	Date signed ///	Ionth, Day Year)	

111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) MAY 3 1

30 Name and address of person who completed cause of death (Item 23a)

H. Speeke

O.C.M.E.

May 24, 2006

State Registrar

			For State Registrar	State of Marylar			of Health a	ind Me		iene	006	16	936
			1. Decedent's Name (First, Middle, Last)						2. Date of Death		V	3. Time o	of Death
В	Physici		NELL	P. CRO	СКЕТТ				Month Mav	27,	Year 2006	8:43	A M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, T	own, or Location of	f Death			ounty of Death		
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Months			8. Date of Birth (Month, Day,	Year)	9. Birth	place (State intry)	or Foreign
Ш	Director		215-14-3227]м 2 XX F 83	Yrs.	WORTH	Days		August 2,			inia	_
	D .	-	Usual Residence of Decedent 10a. State 10b. County	10c C	ity. Town or Lo	eation						10d. Inside (Tity Limits
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	he M	ect	Maryland Somerse 10e. Street and Number	et		10f. Zip (Crisfiel	<u>d</u>	10	no Citize	n of What Cou	intry?	
	with e or	급				TOI. Zip (og. Omzo			
	eath	Funeral Director	246 North Somerse	et Avenue 12. Was Decedent Ever in U	J.S. 13.1	Was Decede	21817	nin? (Spec	ifv Yes or No-	14	USA . Race - Amer	ican Indian.	
	ter d	'n	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo			ent of Hispanic Orig fy Cuban, Mexican,	, Puerto R	lican, etc.)		Black, White	, etc.	
99	urs al	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes 2	No Specify:			S	pecify: W	hite	
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28a-f show than M. Alfed Ezerre not invalled at	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual	Occupation done during most	of working	0	16b. Kind	of Business/l	ndustry	
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7	ad wi	Con	12		Subs	stitut	e Teache				nool Sy	stem	
nd	ba filed nal Hygie ad other	Be	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle, N	Maiden S	umame)		
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Maryland	2 sh and ls m		19a. Informant's Name/Relationship (Ty	pe, Print)			Street and Numbe			50at 1.1			
ď	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mantal Hygiene. If item 27 is marked other than "neturel", or items 23e or 28e-f show or other traumatic event, it is Marked and its marked or a content in the Marked and its marked or other traumatic event, it is Marked in the marked in the marked and its mark		Keith Crockett (So 20a. Method of Disposition		220 N Place of Dispo		Boulevar	d – S		-	Marylan)1
Jor	Pages nent of P int: If ite		1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, crer	natory or oth	her place)						
Baltimore,	it. Pa		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Liceus	1 / 100			al Park M		, 2006 C	risf	ield,	Maryla	ınd
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			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	412.	37	11111	-				Interval Be Onset and	
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse		90	MICICOS	1					
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<u>o</u>	the a	ysic	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4□ Pregnant at time of a 9□ Unknown	death 5L	Other (spe	спу)	· · · · · ·					
<u>α</u>	that the de ed by the detachad	by Physician/Me	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying ca	use given in Part I.		23e. Did tob	acco use	contribute to	the cause of	death?
Vital Records,	uires tha signed I	d by							1 <u> </u> Ye	s 2	No 3□Pro	bably 4 🗆]Unknown
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Re	he lav e has ige 2	Completed							autopsy	led?	prior to co death?	ompletion of	cause of
ta			25. Was case referred to medical				26 Place	of Death	1 ☐ Yes 2 (Check only one	No No	1 L Yes	2□ No	· · · · · · · · ·
	/sicie s cert direct	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA	Other	rsing Hom			Other (Spec	ifv)	
101	Attending Physicien: The lar or death. ector: After this certificate has by the funeral director, page 2		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		lc. Injury at Work?	28	Bd. Describe ho				
jo	ttending I death. ctor: After / the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Four)	,,	М	1 ☐ Yes 2 ☐ N	Vo					
Division of	l or Atten after deatl Director: I in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str ify)	eet, factory,	office	28	Bt. Location (Str City or Town		Number or Rui	a / Route Nui	mber,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific; completely filled in by the funeral director,												
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	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature /	ask B							
	Registr	ar	MAY 3 1 200	10 Bears A	5	3							

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Carl Carter 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ **Medical Examiner** CARL CARTER May 27, 2006 1110 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore City N/A 5. Social Security Number 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. 8irthplace (State or **Funeral** Months Davs Hours 219 52 2839 Director Country) MD. 2 F 56 MAR.4,1950 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d Inside City Limits any 10b, County s 23a or 28a-f show e notified at once. 28a-f show Yes 2 BALTIMORE MD. N/A Director 10e. Street and Numbe 10g. Citizen of What Country 2239 E. 21213 PRESTON ST USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, 8lack, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married Yes 0r. Yes, Give Year 3 Widowed Oivorced Yes 2 XNo specify: Specify BLACK 'natural" þ r Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) 16b. Kind of 8usiness/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) the Medical MD 21215-0036 is marked other than 11TH ASSEMBLY WORKER GENERAL MOTORS 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be LORENZO MORRING VIRGINIA CARTER 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 shr ent of Health and int: If item 27 is r other traumat ROBERT DAVIS 512 LUZERNE AVE. BALTO, MD. 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Oate 20c Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Important: If njury or other Pages 1 crematory or other place) JUNE -@-, TRINITY CEMETERY 2006 BALTOMORE, MD. Bonation 5 Other Specify mature of Funeral Service Licen 22 Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME PRESTON ST BALTO: MD Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line /Medical **O**eath a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Oue to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical physician a the burial -UNPENDEO xx AMENDED 20b per fh g855 5-31-06 vt Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Day Year use as Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of has performed? death? ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other₄ DOA Nursing Home 5 Residence 6 this ဥ 1 🗸 Yes After 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred Certification: May 27, 2006 Driver auto fixed object collision Natural 1128 hrs Pending 1 Yes 2 ✔ No the To the Funeral Director: 2 🗸 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 5700 Erdman Avenue, Baltimore City, Md. determined (Specify) Local Street Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. cal 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME May 28, 2006 anle 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Oate filed (Mark Vay Sear)

DHMH 17 Rev 1/2001

State

Registrar

egistrar's Signat

2006

DHMH 17 Rev 1/2001

Registrar

MAY 3 1 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 8 per fh e856 6-2-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 4a. Facility Name (If not institution, give street and number) 2006 10:45 AM MAY 24 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTO. 2688 EA9/e If Under 24 Hrs. 8. Date of Birth (Month, Zay, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Hours Months 1 ☐ M 2 🐼 F 216-62-738 Usual Residence of Decedent md. Director 10d. Inside City Limits 10c. City, Town or Location 10h County 10a. State or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No BALTO. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21223 4.5 2688 or items 23a Funera 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Marned 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", a eny injury or other traumatic event, tra Mudical Exa. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) ViRgiNiA MC ROBERT E. DAVIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FROST SISTER 2913 MC EldeRRY ST. CARALENA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) wood/AWN MO 26-86 KINGS MEM. AUIS SV. FUNERAL Home 22. Name and Address of Facility

Wesley

And

2007 EA 21. Signature of Funeral Service Licenses ASTERN AVE. BALTO MASINS Wesley 23a. Part1. Enter the disease, a complications that cause it shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) FALWRE **Physician** /Medical Due to (or as a consequence of): Examiner METASTATIC WLORGERAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner anding physician and use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending for use as IF FEMALE 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached t 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by HUSTITERSIN 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has i autopsy performed? certificate 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?

1 \(\text{Yes} \) 2 \(\text{N} \) director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 1747934 ad address of person who completed cause of death (Item 23a) (Type, Print) BATIMORE MD 401

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) MAY 3 1 2006

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32. Registrar's Signature

		4	For State	State of Ma	aryland		artment of H		d Mental		000		
			Registrar 1. Decedent's Name (First, Middle,	Laşt)			tincate of L	Jealii	2. Date of		1- U U	3. Time o	f Death
п	Physici /Medic		CHARLES	William	1) 13	EHL	- SK		Month	2 Q		1 4	PM
7	Examin		4a. Facility Name (If not institution,				4b. City, Town, or	Location of D		40	. County of De		
				griew Medical 6. Sex 7. Ag	Cente	2	ONHW II Under 1 Year	If Under 24 I	Hrs a Data	4 Diah	NA		
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	D.		Usual Residence of Decedent						12	0-1520			
	ehow	ž	10a. State 10b. County	т штморг	10c. City,	Town or Lo		CONTRACTO	•			10d. Inside C	ity Limits 2 No
	28a-f	Director	MD BA	LTIMORE			10f. Zip Code	SEDALE	1	10a. C	itizen of What (
	3a or	0	1806 WILHELM	AVENUE				21237				5.A.	
	eme 2	iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin?	? (Specify Yes o	r No-	14. Race - Am Black, Wh		
36	, or it	by Funeral	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4XXX Divorced	ed 177 Yes 2	No		1□Yes 2XINo	Specify:		´	Specify:	WHITE	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "neturel", or Iteme 23a or 28a-f show or other traumatic event, the Madical Examinationus be notified at		15. Decedent	Year or Dates:		16a. Dece	dent's Usual Occupa	ation		16b. F	Cind of Busines		
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and	lid be fil fental H rked oth	Be	17. Father's Name (First, Middle, L		AT LINET				Name (First, Mi				
Maryland	should and Men marke	ဥ	RUSSELL C		DIEHL	19b. Maili	ng Address (Street a	IRENE		NCHE umber, City	(HEP)		
	ealth and m 27 le m		MICHAEL DIEHL/				BRIGHTSID			SEDALE		21237	
ore,	es 1 a of Hei f Item r othe		20a. Method of Disposition 1 Burial 2 Cremation	2 Domain from State	20b. Plac	ce of Dispo	sition (Name of matory or other place	1	Date		ocation - City o	r Town, State	
Ĕ	Pages ment of ant: If It	ļ	4 Donation 5 Other (Sp		GARR	ISON	FOREST VE	TC 6	-1-2006	OWI	NGS MI	LS, MD	
Baltimore,	permit. Pages Department of Important: If II eny injury or once.		21. Signature of Funeral Service L	icensee	1_		2. Name and Addres		CVACH/ROUE RO		E FUNE E, MD	RAL HOME 21237	;
			23a. Part I. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each li	the death.	Do not en	er the mode of dying	g, such as car	diac or respirato	ry arrest,		Approxima Interval Be	tween
1	Physician		Immediate Cause (Final disease or condition	- Meta	stati	L B	ladder	Carci	no un A	3		Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce ol):							
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Вох	that the death cer ed by the attendir detached for use	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal d	eath 3[Ectopic pregnancy Other (specify)			_ 1	Month Month	-	Year
P.O.	t the by th tache	hys	9 Unknown	9□ Unknown									
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0	ng Ph fter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju	y Year) 2	8b. Time o	f 28c. Injury Work				iry occurred		
Sio	Attending r death.	catio	2 Accident investig	ation			M 1 🗆 Y	Yes 2 □ No					
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	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	edicai C	29a. Certifier 1 Certifying (Check only 2 Medical I	g Physicien: To the best Examiner: On the basis of	of my knowl	edge, deat	h occurred at the tim	ne, date and pl	lace, and due to	the cause(s	s) and manner a	as stated.	
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	₹ <u>₹</u> 8		12120 -	(1= A/A				5-00	00	114			
	101		30. Name and address of person	no completed cause of c	leath (Item 2	3a) (Type.		ال د		Ma	7 26,	2006	
	54 '		M. Edumendo	Justine 494	C EM	EAN A	1. Baltim	one, M	1 212	24			
	Sta		31. Date liled (Month, Day, Year) MAY 3 1	2006 32/Registr	rar's Signatu	re A	344						
	Registi	ar	шигот	LOOU JUSTIN	2 15	J.S. L.							

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) May 22, ^{Day} 2006 **Physician** Robert Davis Edwards 2231 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth
Jul 21, Year 1932 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**XM 2□ F Months Days Hours 578-42-9885 73 Washington DC Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County th and Mental Hygiene. If is marked other than "natural", or items 23s or 28s-f ehow traumatic event, the Medical Examinar must be notified at Frederick Knoxville Maryland 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3780 Maplecrest Court 21758 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural, or items 23a any injury or other traumatic event, the Medical Examiner mustal once. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Navy 1 XYes 2 No If Yes, Give Reserve 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Fabrication/Design Trainer/Simulators 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Shell Davis Edwards 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Grace Moon Davis, Wife 3780 Maplecrest Ct, Knoxville, Maryland 21758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Mt Olivet Cemetery May 27,2006 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Keeney & basford P.A. Funeral Home
106 East Church St, Frederick, Maryland 21701 21. Signature of Funeral Service Licent whom Koleson MOO706 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardiovascular Disease **Physician** Muerosclerotic disease or condition resulting in death) Yeavs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner anding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical ettending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the e 1 ☐ Yes 2 ☐ No of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peeu 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 △ No certificate 2×No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Inpatient 2 XFR/Outpatient ٩ 3□ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending i after death.

I Director: After din by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital o within 24 hours aft To the Funerel Di 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37197 May 24, 2006 Eures 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.M.E., 15 West Seventh Street, Frederick, Maryland 21701 Alan H. Rohrer, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 3 1 2006 Registrar

			For State Ragistrar	State of Maryl	and / Dep		lealth and M	lental Hy	_	300	16942
			Decedent's Name (First, Middle, Last))				2. Date of Dea	ath		3. Time of Death
	Physicia		Alvin N.	DeSesa				Month	Day 2	Year OO 6	5': 25 PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County		
			Sinai Hospital of	Baltimore		Baltimor	e City				
	Funeral		5. Social Security Number 6. Se		yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birt	h v, Year)	9. Birthp	place (State or Foreign
	Director		106-22-4149]M 2□F	77 Yrs.			Feb. 26	,1929	New	York
	and *	-	Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or L	ocation				1	0d. Inside City Limits
9	Aaryli f eho	5	Maryland Baltimor	e	Timo	nium					1 ☐ Yes 2 ☐ No
365	286-	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Cour	ntry?
Desesa	death with the Maryland me 23a or 28e-f ehow rmust be notified at	Funeral Director	2135 Eastridge Roa	ď		21093			United	State	25
	death	nera	11. Marital Status	12. Was Decedent Ever in Armed Forces?	in U.S. 13.	Was Decedent of H					can Indian,
Alvin	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28e-f ehow eny injury or other traumatic event, the Medical Examiner must be notified at once.	Fu	1 ☐ Never Married 2 ☑ Married	1 ☑ Yes 2 ☐ No		1 ☐ Yes 2 🔀 No	Specify:	, noan, orc.,		∞. Whi	
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Ş₽	Hygi other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Surnan	ne)	
3 <u>a</u>	lid be fental rked c	To B	Dominic DeSes	a			Ines	Giovan	ucci		
nt Knawa as Alvi Maryland 21215-0036	should land Men and Men smarke		19a, Informant's Name/Relationship (T)	vpe, Print)	19b. Mail	ing Address (Street	and Number or Run	al Route Numbe	r, City or Town,	State, Zip	Code)
नेपर्नातम Known Baltimore, Maryland	and 2 saith a n 27 is		Alba M. DeSesa, W			Eastridge					
T-	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		b. Place of Disp cemetery, cre	osition (Name of amatory or other place		Date	20c. Location -	City or To	own, State
BE	Pages ment of ant: If it ury or o		4 □Donation 5 ☑ Other (Specify)			Lley Mam. G			Timonium,		
Salt	permit. Depertr Imports eny inf		21. Sign sure of Funeral Service Licens	(A)		22. Name and Addre					
	40 - a	. !	MUMBER WAR	M01113		ılaney Valle				ium, 1	
-			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line.	death. Do not er	iter the mode or dyin	ig, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Adult R	espirator	y Distress	Syndrome	•			13 days
	Examiner			Due to (or as a con	sequence of):	•	,				12 16 6
		e.	Sequentially list conditions, if any, leading to immediate	Due to (ras a con	nsequence of):						13 days
	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
oʻ.	re be executed	Exa	resulting in death) Last	Due to (or as a con	nsequence of):						
760,	ysicie	cai		đ							ne Ber
Box 68	ng ph	Med	IF FEMALE:								
õ	th ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I	Fetal death 3	□Ectopic pregnancy	,			te of delive onth	ory Day Year
E	Attending Physicien: The law requires that the death certifical r death. ector: After this certificate hes been signed by the attending phy by the tuneral director, page 2 should be detached for use as the	Completed by Physician/Medi	1 Yes 2 No	4□ Pregnant at time 9□ Unknown	of death 5	Other (specify)			1010	,,,,,,	Day 1 dai
P.0	hat the deby detach	F.	Part II. Other significant conditions co	otributing to death but got	resulting in the	underlying cause giv	en in Part I	23e Did to	nhacen use cont	ribute to th	ne cause of death?
ds,	signe d be d	ğ	Coronary Artery Di		rosaming in the	aridonying oddoo giv	on are diversi		′es 2 □ No		pably 4 Dunknown
or	requ been shouk	ete	COLUMN STEP DI	3003-2				24a. Was	- 045		•
Rec	hes pe 2 s	m						auton	SV	prior to co death?	psy findings available mpletion of cause of
ā	n: Th	မ င	OS Was area referred to medical					1 ☐ Yes	2 54 No	1 🗆 Yes	2 📈 No
<u>=</u>	sicie s certi iirecti	8	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1751 Innation	2 ER/Outpatie	ent 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho			or (Specif	
ō	a Phy ar this aral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Yea				28d. Describe h			γ)
ion	ath. r: Afte	atio	1 🖾 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ir) Injury		K? Yes 2 □ No				
Division of Vital Records, P.O.	er der er der recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A	At home, farm, s	treet, factory, office		28f. Location (S City or Tow	Street and Numb	er or Rura	il Route Number,
Ö	rs after or at Direction	Cer		J			ļ				
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and to the Funeral Director. After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Medicai	(Check only 2 Medical Exam	rsician: To the best of my iner: On the basis of exar	knowledge, dea mination and/or i	th occurred at the tirnivestigation, in my o	ne, date and place, pinion, death occur	and due to the ored at the time, or	cause(s) and ma date and place,	anner as s and due to	tated. o the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
	8 4 2 4		Davide 11.	2.1 2.1			S-00 O		NA		
	1		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type				1 dy	-1,6	,006
	8						iltimore.				
	Sta	te	31. Date filed (Month, Day, Year)	22. Registrar's S	Signature	al of Bo					
	Registr	ar	MAY 3 1 2006	Blown 1	y Ana	W.					

		State of Maryland / Departi			2000	16943
	200	= State Registrar Amend #10e Per FH C856 6/15/06 Jh Certif 1. Decedent's Name (First, Middle, Last)	Cate of Death	2. Date of Dea		3. Time of Death
Physicia /Medic		Jannet Davis		May	26,2006	8:42 PM
Examin	er	4a. Facility Name (If not institution, give street and number)	3 Altimor	0	4c. County of Death	1
Funeral		1		er 24 Hrs. 8. Date of Birt	y, Year) 9. Birthp Coun	lace (State or Foreign
Director		217-60-3239 1 M 2 TF 53 Yrs. M	Jillis Days Flours	July 9	1,1952	" Md
yland		10a. State 10b. County 10c. City, Town or Location	on		1	Od. Inside City Limits
Sa-f.	ctor	Md N/A Baltime				1 Yes 2 No
with the		10e. Street and Number #228	Of. Zip Code		10g. Citizen of What Cour	itry?
d 21215-0036 filed within 72 hours after death with the Maryland Hygien. ther than "natural", or items 23a or 28a-f show with the Marical Evand or man tea notilied at	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic C s, specify Cuban, Mexic	Origin? (Specify Yes or No		
36 s after , or ite	by Fu	1 Never Married 2 Married 1 Yes No	Yes 2 No Specif			ac K
21215-0036 of within 72 hours att glene. Then "natural", or then "natural", or the Mudical Evertal	ted b	15. Decedent's Education 16a. Decedent	s Usual Occupation		16b. Kind of Business/Ind	
215 ithin 7 in or	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	of work done during mo NOT use retired)	ost of working	Rican	0_ 11
nd 21 s filed w I Hygier other th		9+h 17. Father's Name (First, Middle, Last)		her's Name (First, Middle,	Ketiremen	Home
yland ; ould be filed Mental Hyg arried othe	To Be	Bobbie Lee Davis	Λ.	agline S	Banders	
2 sh and and sum		N. ()		A	er, City or Town, State, Zip	Code)
The The The		Maglene Pannell Mother 5008 20a. Method of Disposition 20b. Place of Disposition	Frankford	Ave Balt	20c. Location - City or To	21206
Mor mor mor mor mant of lints: If litt		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	ry or other place)		Randallston	
Baltimor permit. Pages Department of I Important: If its any injury or o					- Harris Fu	
W #8 # 8					Himore Md	
		23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final	e mode of dying, such a	as cardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):				1 genr
Examiner		Sequentially list conditions b.				
\$ 84 D	Iner	fl any, leading to immediate dause. Enter Underlying Cause (Disease or injury				
L/OC 760, te be executed ysician and	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):				
8760 sate be ohysicia	dlcal	d				
x 68 willing ph	Med	IF FEMALE:	70° (N/20° 5 - 111°)			
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Me	If the past 12 months:	opic pregnancy ner (s <i>pecify</i>)		23d. Date of delive Month	ry Day Year
P.O. I that the de detached is	hysi	1 Yes 2 No 4 Pregram at time of death 5 Off				
S, F	by P	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Par		obacco use contribute to th	
Records,	eted	They ditis C, syphilis				ably 4 Unknown
I Reco	dwo				sy prior to condeath?	sy findings available pletion of cause of
	Be C	25. Was case referred to medical examiner?	26. Plac	1 ☐ Yes ce of Death (Check only o	22 No 1 ☐ Yes	2 L No
hys his	္	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3			lence 6 Other (Specify	Horpia
on o ding Ph h. After th funeral	Certification:	27. Manner of Death 1 ★ Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year) Injury	28c. injury at Work? VI 1 ☐ Yes 2 [ow injury occurred	
	iffca	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, building, etc. (Specify)			Street and Number or Rura	Route Number,
Div Div spital or A spital or A sours after soral Dirac		, , , , , , , , , , , , , , , , , , , ,				
등 등 등 등 등	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occupance of the control of the c	curred at the time, date a gation, in my opinion, de	and place, and due to the death occurred at the time, o	cause(s) and manner as st date and place, and due to	ated. the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, I	Day, Year)
		Swilliam Benedier, no	D808	3583	5/28/00	
2		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	*	P		
Sta	te	G- William Switch (50 W - 1) 31. Date filed (Month, Day, Year) 32. Adjustrar's Signature	- HH VILLE SI	, BANTIMOZO	MD, 2/217	
Registra		MAY 3 1 2006 See & Son	W			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2 Detect Death

				State of Ma	iryiand	•			nealth and i Death	_	Reg. No.2	06	16944
	Physicia	an	1. Decedent's Neme (First, Middle, Last)	_	,	1 -				2. Dete of De Month	Day	Yeer	3. Time of Death
	/Medic	al	Katherine 4e Fecility Neme (If not institution, give s	<u></u> ∠ , treet and number)	Kn	Sler			4b. City, Town, or	う Location of Deat		2009 y of Death	1:50 Am
	Examin	er	Oakcrest 88	32 Wa	1the	Bluo			Parkull		Ba	Himoi	121734
	Funeral Director		5. Social Security Number 5/0 44 00 95 Usuel Residence of Decedent	M 201F 7. Age	(In yrs. la	ast birthday Yrs.	Month	er 1 Year s Deys	If Under 24 Hrs Hours Min.	(Month, Da	th ly, year) 0/15	9. Birthplece Country)	e (State or Foreign OKlohoma
	yland how		10a. Stete 10b. County		10c. City	, Town or L	ocation						Inside City Limits
	he Ma	Director	Maryland Baltimor	e		Pa	rkvi				10g. Citizen of		1 □ Yes 21X No
	3a or		10e. Street end Number 8832 Walther Blvd.				101. 2	ip Code 212	23/4		100	SA	
	deeth	Funerai		2. Was Decedent E Armed Forces?	ver in U,	S. 13.	Was Dec		dispanic Origin? (S an, Mexican, Puer	pecify Yes or No		ce - American I ck, White, etc.	
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health end Mental Hygiene. Important: if item 27 is merked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ Ñ If Yes, Give Year or Dates:	io				Specify:			r: white	
15-0	"natur	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Dece	edent's Us e kind of v	vork done	pation during most of world)	rking	16b. Kind of B	susiness/Indust	ry
212	y within	ошо	Elementery/Secondary (0-12)	College (1-4or 5- 4	+)		Iomem		-7		Ot	wn Home	<u>.</u>
P	al Hygin	Bec	17. Father's Neme (First, Middle, Last)						18. Mother's Nar			ne)	
ryla	should be and Mental s marked or umatic eve	၉	Theodore Chambers 19a. Informant's Name/Relationship (Type			10h Mai	ling Addre	ne (Straat	Adela and Number or Re	ine Fe		State Zin Co	del
Ma	and 2 sho ealth end n 27 is m	!	Diana Engler, Dau			1			ord Way C				
ore,	of Health of Health Item 27 r other tr	114-	20a. Method of Disposition 1 Durial 2 Cremation 3 Re		20b. Pi	lace of Disp	osition (A ematory o	lame of r other plac	ce)	Date		- City or Town,	
ti m	. Pag ment ment: if tant: if jury o		4 ☐ Donation 5 ☐ Other (Specify)		Met	cro Cr			Inc.	05/30/06	Baltimo	ore, Ma	ryland
Ball	permit. Pages 1 an Depentment of Heal Important: if item 2 any injury or other once.	1	21. Signature of Funeral Service Librase Thomas Gregor	7		2	Crem 299	^{and Addre} ation Frede	ss of Facility n Society erick Roa	Of Mar	land In	nc. arvland	21228
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused a cause on each lin	the death	. Do not er	nter the m	ode of dyir	ng, such as cardia	or respiratory a	rrest,	App	proximate erval Between
	Physician /Medical		Immediate Cause (Final disease or condition	P	nei	line	oni	a				On	nset and Death
	Examiner	_	resulting in death) a.			es a conse							
8	d diameter	Examiner	b.		Due to to	as à consc	and the second	th:					
6	e exec ian en uriel-tr	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.			40 4 00 114	.,,	.,.					
,09289	physic physic s the b	edicai	that initiated events resulting in death) Last	C	Due to (or	as a conse	quence of	f):					
Box (n certifi anding use et		d.										
о С	e death the ette	Physician/M	Part II. Other significant conditions cont	ributing to death bu	not resu	Ilting in the	underlying	g cause giv	ven in Part I.	23b. DId	tobacco use co	ontribute to the	e ceuse of death?
, P.O.	thet the		Dialetes	mell	CIT	us				10	Yes 2□ No	3 Probabl	ly 4 ☐ Unknown
Division of Vital Records,	en sign	Completed by									an autopsy ermed?	availab	autopsy findings ble prior to
Sec Sec	lew re nas be e 2 sh	npie									/	of deat	etion of cause th?
<u>e</u>	n: The licete t		OF Manager of and Manager						00 81(8	1.0		1 □ Ye	es 2 No
Z.	s certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 1 No	ospital:	nt 2 🗆 l	ER/Outpatie	ent 3□I	DOA Oth	ser /	ath <i>(Check only d</i> lome 5 ☐ Resi		ner (Specify)	
n o	ng Phy fter thi ineral	L:uo	27. Menn of Death	28a. Date of Injur (Month, Day	Year)	28b. Time Injury		28c. Injur Wor	rk?	28d. Describe	how injury occur	rred	
isio	ttendii deeth. stor: A the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	rv - At ho	me farm s	M treet, fact		Yes 2□No	28f. Location (Street and Numi	ber or Rural Ro	oute Number.
Div	To the Hospital or Attending Physician: The lew requires that the death certificate be executed, within 24 hours efter deeth. To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the bunel-trensit	Certification:	4 Homicide determined	building, etc			iloot, laot	ory, omeo		City or To			
	Hospit 24 hour Funera tely fill	edical	29a. Certifier 1 D Certifying Physic (Check only one) 2 Medical Examine	er: On the basis of	examinati								
	To the within ? Fo the comple	₩ .	29b. Signature and title of certifier	end menner stat	2		2	9c. Licens	se number	-	29d Pate signe	nd (Month, Pay	, Year)
	^		1/2/		V_{-}			D-	37687		3/2	0/00	
	12		30. Name end eddress of person who cor	npleted cause of de	eeth (Item	23a) (Type	Print)	Blu	d, Pa	NLLVI	le, t	107	1234
	Stat	te	31. Dete filed (Month, Day, Year)	32. Pegistre	r's Signet	ture	make	B					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 10:10am M 21 2006 May Peggy Mae Everett /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Laurelwood Care Center Elkton Cecil If Under 1 Year 8. Date of Birth (Month, Day, Year) 01/07/1924 Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours Min. 1 □ M 2 1 F Yrs. 82 Maryland Director 213-32-2851 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 Is marked other than "natural", or Itams 23a or 28a-f show traumatic avant. The Medical Equit at most be notified at 1X Yes 2 No Director Havre de Grace MD Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 128 Bloomsbury Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: specify: White ģ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is markad other than ' Elementary/Secondary (0-12) College (1-4or 5+) 9th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bertha Mae Green David Thomas Lloyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Peggy J. Hamm- Daughter 128 Bloomsbury Ave., Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State ŏ permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Harf. Mem. Gardens 05/26/06 Aberdeen. MD Approximate shock, or heart failure. List only one cause on each line. 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. Onset and Death Immediate Cause (Final 10 THRIVE **Physician** ALLUNE disease or condition resulting in death) /Medical o (or as a consequence of): Examiner AIROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury b Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit DREASE GNS 5746 E that initiated events ned by the attending physician and detached for use as the burial-trail resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Unknown peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? A No certificate 1 ☐ Yes 🔑 ☐ No 1 Tyes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) SIL 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After ! I or Attanding F after death. Natural 5 Pending 1 ☐ Yes 2 ☐ No investiga 2 🗋 Accident the Diractor: 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital of within 24 hours at To the Funaral D Co. Using Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number ton erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address 31. Date filed (Month, Day, Year) STON HURCHMANS 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

1 2006

	1 For State	State of Maryland /	Department of Health and Certificate of Death	Mental Hygier	e 2006 16946
	Registrar 1. Decedent's Name (First, Middle, Las	it)	Certificate of Death	Reg. N	3. Time of Death
Physician /Medical	Ethel Louis	e Edwards		May 2	7, 2006 1215 pm
Examiner	4a. Facility Name (If not institution, give	Street and number)	46 City, Town, or Location of Dec	Cify	ć. County of Death
Funeral	5. Social Security Number 6. So	9X 7. Age (In yrs. last bi	irthday) If Under 1 Year If Under 24 H Yrs. Months Days Hours Mi	n. (Month, Day, Yea	9. Birthplace (State or Foreign Country)
Director	213-34-7097 Usual Residence of Decedent			July 26,	
Signature of the Maryland after death with the Maryland or items 23e or 28e-f show marker must be notified at Funeral Director	10a. State 10b. County		vn or Location		10d. Inside City Limits 1 Yes 2 □ No
r 28a-l	10e. Street and Number	عرا	Himore 10f. Zip Code	10g. (Citizen of What Country?
ath witt	1010 W. Balt		413 21223		USA
fitter death with the Mar ritems 23e or 28e-1 st inferent De notified Funeral Director	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
≥ 8 8 € 1 6	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1 ☐ Yes 2 No Specity:		Specify: Black
21215-00 ed within 72 ho ygiene. Per then 'naturu it, the Madical it, the Madical Completed	15. Decedent's Ed (Specify only highest gra	de completed)	 Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) 	rorking	Kind of Business/Industry
d 2121 d 2121 filed within Hygiene. Ither then ont, the Mac	Elementary/Secondary (0-12)		aborer	Fa	rming
Be Sell	17. Father's Name (First, Middle, Last)	•	18. Mother's N	ame (First, Middle, Maide y Johnso	4
laryla sand Ment is market aumatic	19a. Informant's Name/Relationship (1		b. Mailing Address (Street and Number or I	Rural Route Number, City	
re, Merit and 2 it Health a item 27 is other trans	George Quee		718 Eastman Ro		town Md 21133
> 9 8 PE 5	20a. Method of Disposition TSurial 2 Cremation 3 4 Donation 5 Other (Specify	Memoval Itom State	of Disposition (Name of ery, crematory or other place)		Notation - City or Town, State
mait.	21. Signature of Funeral Service Licen				Jarris Furniral Hom
o 83.5 8		Nio	5240 Reisterstow	N Prod Ba	timore Md 21215
Dhysisian	shock, or heart failure. List only	one cause on each line.	not enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death)	a. Due to (or as a consequence			
Examiner	Sequentially list conditions,	Due to (or as a consequence	ot).		
executed in and inial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Renal A	where		
6760, cate be executed the burial-transit title burial-transit closed	resulting in death) Last	Due to (or as a consequence	of):		
68760, c		d			
Box 6 eath certifications attending attending attending attending attended at the celan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal deatl	h 3⊟Ectopic pregnancy		23d. Date of delivery
P.O. Box hat the death cert of death cert death cert death cert death for use a detached for use a Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)		Month Day Year
cords, P.O. wrequires that the de been signed by the should be detached		ontributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ord: require een sig	Ventilator	HESPITATORY	railure	1 ☐ Yes	2 No 3 Probably 4 Unknown
II Records, The law requires to page 2 should be Completed by				24a. Was an autopsy performed2	24b. Were autopsy findings available prior to completion of cause of death?
Vital Ficien: The certificate sector, page			26. Place of D	1 ☐ Yes 2 ☑ N eath (Check only one)	lo 1 Yes 2 No
of Vita Physician: this certific	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/O		Home 5 Residence	
on on or or or or or or or or or or or or or	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred
Division of Vital Records, teal or Attending Physician: The law requires the street death. The Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
S S S S O		ysician: To the best of my knowledge	e, death occurred at the time, date and pla	ce, and due to the causel	s) and manner as stated
the Hosp thin 24 hou the Fune impletely fil	(Check only 2 Medical Exam	niner: On the basis of examination as and manner stated.	nd/or investigation, in my opinion, death oc	curred at the time, date a	nd place, and due to the cause(s)
To t of To t	29b. Signature and title of certifier	_	29c. License number	¥ 29d. D	ate signed (Month, Day, Year)
	30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print)		-401104
9	Kosalyn	Baker, M. D.	90 Mary land	Grenera	Il Hospital
State Registrar		32. Pogistrar's Signature	Scools?		

ORIGINAL

/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed P.0. been signed by the should be detached of Vital Records, certificate has b : After this certifice a funeral director, r Division death. Director: A filled in by ō within 24 hours a To the Funeral L To the Hospital completely

Show

filed within 72 hours after

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Maryland 21215-0036

Baltimore,

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NISA Maruthur 31. Date filed (Month,) Y 3 1 2006

29b. Signature and title of certifier

600

RES-000 MD

29c. License number

29d. Date signed (Month, Day, Year)

28, 2006

Wolfe Street, Baltimore, Maryland North

2. Registrar's Signature Garalles

			For State Registrar	•	aryland / Dep		lealth and M	lental Hygi	_	5 1601.0
			Decedent's Name (First, Middle, La.	st)				2. Date of Death		3. Time of Death
	Physicia /Medic	al .	HARRY BLA	INE FRO	51 Jr.	45 City Town	or Location of Death	Month MAY	30 200 4c. County of De	56 2A M
1	Examin	er	4a. Facility Name (If not institution, giv		-161.0					alli
			UARBOR HO 5. Social Security Number 6.5	SPITAL CE	e (In yrs. last birthday		TIMURE If Under 24 Hrs.	8. Date of Birth	N/A	idholace (State or Foreign
	Funeral Director		214-26-0779	M 2□F	77 Yrs.	Months Days	Hours Min.	March 18,1	929 Ma	irthplace (State or Foreign Country) ryland
	p	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	a-f sho	ctor	Maryland Baltimo	ore	Dunda					1 ☐ Yes 2 🔀 No
	3a or 28	I Dire	10e. Street and Number 7515 School Avenu	i e		10f. Zip Code 212	22	10	g. Citizen of What (USA	Country?
	me 2	ere	11. Marital Status	12. Was Decedent	Ever in U.S. 13	Was Decedent of h	Hispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or No-		nencan Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or Iteme 23a or 28a-f show supprintury or other traumatic event, the Medical Frain and the notified at Andre.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 1 ØYes 2 ☐ N If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☑ No		rican, etc.)	Specify:	white
ŏ	2 ho	ted	15. Decedent's E	ducation	16a. Dec	edent's Usual Occup	pation	ing 1	6b. Kind of Busines	s/Industry
75	hin 7	be	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retire	during most of work d)	ing		
21	A COLOR	mo.	8 years			o Worker			General M	otors
b	oth oth	BeC	17. Father's Name (First, Middle, Last				18. Mother's Name			
<u>a</u>	ld be kenta	To E	Harry Blaine Fros	st Sr.			Dorothy	E. Jones		
Maryland	12 shound N and N is mail		19a. Informant's Name/Relationship (Joanne Hemling	Type, Print) Daughter			and Number or Rura Avenue, E			. Zip Code) 1221
ص ص	Tand Healt Im 2		20a. Method of Disposition	Daugnter	20b. Place of Disp				Oc. Location - City	
Baltimore,	Pages nent of H int: If ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	cemetery, cre	ematory or other pla Crematory	ce) Jun	e 3,	altimore	
Balti	permit. Departn Imports eny inju		21. Signature of Funeral Service Lice	onno	llu-	Connelly 7110 Soll	Funeral H.ers Point	ome Of D	undalk.P.	Α.
			23a. Part1. Enter the disease or comshock, or heart failure. Ust only	plications that caused						Approximate Interval Between
	Physician		shock, or neart tailure. List only Immediate Cause (Final disease or condition resulting in death)	a	SEPSIS					Onset and Death
	/Medical Examiner		1		a consequence of):	ASSOCIATES	D PNEUM	ONIA		300 Ays
b	bed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):					2 YEARS
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P.O.	t the de by the c	hys	9 🗆 Unknown	9 Onknown						
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Ö	requ	ete		•				04- 145	Tou	Contract Laboratory
Division of Vital Records,	The la	ompl	LARI) 10 MYDPATI	44			24a. Was an autopsy perform	prior to	autopsy findings available completion of cause of
ita	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)	
*	Physicien: this certific ral director,	To	1 ☐ Yes Z☐ No	Hospital: Inpatie	ent 2 ER/Outpatio	ent 3 DOA Ott	ner: 4 🗆 Nursing Ho	me 5 Resider	nce 6 Other (Sp	pecify)
0	A 0 0		27. Manner of Death 1. □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injury		ry at rk?	28d. Describe ho	w intury occurred	
<u>.</u>	Attending r death. ector: After by the fune	atlc	2 Accident investigation	n]Yes 2□No			
Divis	after de after de Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of Ini	ury - At home, farm, s c. <i>(Specify)</i>	treet, factory, office		28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,
	To the Hospital or Attanding within 24 hours after death. To the Funeret Director: After completely filled in by the fun	edical C	29a. Certifier A Certifying Pl (Check only one)	hysician: To the best miner: On the basis o and manner st	f examination and/or i	ath occurred at the ti investigation, in my	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	o thi o thi ompli	Me	29b. Signature and title of certifier	. 111		29c. Licens	se number	29	d. Date signed (Mo	nth, Day, Year)
	/\ \			leg LA	4 KHIN, M	D f	65 000		MAY 30, 20	06
	1		30. Name and address of person who	, 3001 8	WAY HIVE	OVER ST.	BALTIMOR	e,MD	2:225	
	Sta		31. Date filed (Month, Day, Year)	. Registr	ar's Signature	de				

			1 - For State Registrar	State of Maryla	nd / Depa	artme		ealth and	Mental Hy	giene	06	16949
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) Sandra M. 4a. Facility Name (If not institution, give s	Foster		4b. C	-	ocation of Dea		9 200 4c. Coun	Year of Death	3. Time of Death 5 · YoA M
<i>₹</i>	Funeral Director		Social Security Number 6. Sex	nter 7. Age (In yrs	. last birthday) 7 Yrs.	If Un Monti	der 1 Year	hervi If Under 24 Hr Hours Mir	s. 8. Date of Birt		9. Birthp Cour 9 Ma	e place (State or Foreign aryland
	ih the Maryland or 28a-f show	Irector	10a. State 10b. County MD Baltimo		Essex		Zip Code			10g. Citizen o		1 ☐ Yes 🏋No
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28s-f show or other traumatic event, the Muclical Examinant must be rectified at	by Funeral Director	2 Haley Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:		_	2122 cedent of His pecify Cuban		Specify Yes or No- rto Rican, etc.)		ace - Americ ack, White, ify: Whi	etc.
S	filed within 72 hor Hygiene. other than "natura ent, the Mudical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 8th		16a. Dece (Give life. Comp	dent's U kind of DO,NOT UTE		ring most of wo		16b. Kind of	on	dustry
	S should be fit and Mental H is marked off	To Be	17. Father's Name (First, Middle, Last) Leslie T. Jar 19a. Informant's Name/Relationship (Ty)		19b. Mailir	ng Addre		Anna	me (First, Middle, Mellard Bural Route Numbe	l		Code)
Je,	Pages 1 and 2 nent of Health ant: If Item 27 I		Jean M. Geier 20a. Method of Disposition 12 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b.	2 H. Place of Dispondentery, cremetery, cremetery	sition (f	lame of r other place.		Date 5/1/06	ID 212 20c. Location Baltin	- City or To	
Balti	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service License	1 Connel	lyc	onn	and Address	Funera	00 Mace	of Es	Balt	O. MD 21221 Approximate
	Ine law requires that the death certificate be executed the law requires that the hes been signed by the attending physician and law law law law law law law law law law	dical Examiner	23a. Part1. Enter the disease, or complications, shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecuence to (or a))).	QUENCE of): A PY K quence of):	7	O FA	TIVE				Interval Between Onset and Death Won Cro
.O. Box 68	at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	ac. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al déath 3 🗆		pregnancy (specify)				ate of delive	ry Day Year
Records, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the ur	derlying	cause given	in Part I.	23e. Did tol		tribute to th	e cause of death?
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\ \	S S	To B	examiner?	ospital:	ER/Outpatien	3 🗆 1	1 04		dome 5 Reside		har (Snacify)
	tending feath. for: After the funer	Certification:	27. Manner of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury a Work? 1 ☐ Ye		28d. Describe ho	ow injury occur	rred	
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:	n 24 t	edical	one)	and manner stated.	ition and/or inv	estigatio	on, in my opin	ion, death occi	irred at the time, di	ate and place,	and due to	the cause(s)
	within 2 To the	M	29b. Signature and title of certifier			2	9c. License n	umber	25	9d. Date signe	ed (Month, E	Day, Year)
7			S' fup!	e MD		1	0005	3150		MAY.	30 Ch	2006
	5	V. A	30. Name and address of person who con	npleted cause of death (Iter	n 23a) (Type, I	Print)		Ron	1 8 . +	2 110	Cow	mbic
	Sta Registr		31. Date filed (Month, Day, Year) MAY 3 1 2006	npleted cause of death (Iter Suphe 96 Registrar's Signa	ature	Sist.	1490	-200	, 044	2110	.70	27047

			1 - For State Registrar	State of Maryland		artment of H			iene2 () () (6 16950
	Physic		Decedent's Name (First, Middle, Last) Eugene Fedoruk					2. Date of Dea Month	th Day Year	/ (1 th) (2 tr
	/Medi Examir Funeral Director		4a. Facility Name (If not institution, give single Pacific Name (If not institution, give single Security Number 6. Sex	treet and number) LURE HOST 7. Age (in yrs. li	of tal	Rose	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March	4c. County of De	
	D		Usual Residence of Decedent 10a. State 10b. County		, Town or L	ocation				10d. Inside City Limits
	deeth with the Maryland ms 23a or 28a-f show	Funeral Director	Maryland Harford 10e. Street and Number	Jop	pa	10f. Zip Code			10g. Citizen of What	1 Yes 2 XNo
\widetilde{n}	h with 23a or	al Di	2404 Old Mountain	Road Central		2108	5		USA	
2	r deet	ner	11. Maritat Status	Was Decedent Ever in U.S Armed Forces?	S. 13	. Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
57 %	hours after turel', or ite	þ	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No tf Yes, Give Year or Dates: WW	II.	1 ☐ Yes 2 🕱 No	Specify:		Specify:	White
Euc 1215-003	na na	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of work	ing	Utility- Gas and	
d 21	Hygie Hygie		17. Father's Name (First, Middle, Last)	4			18. Mother's Name	e (First, Middle,		
R CK	2 should be filed within and Mental Hygiene. Ie marked other then aumatic event, the Mental Count, the Mental Count, the Mental Count, the Mental Count, the Mental Count, the Mental Count, the Mental Count, the Mental Count, the Mental Count, the Mental Count, the Mental Count, the Mental Count, the Mental Count, the Mental County, the Mental County, the Mental County County, the Mental County Coun	To Be	Karp Stephen	Fedoruk	1		Selma	Pauli		
ි දි Mar	es 1 end 2 sh of Heelth and fitem 27 ie m r other traum		19a. Informant's Name/Retationship (Type Nancy Turner-Fedor						r, City or Town, State , Joppa, I	
Edmore	Pages 1 enert of He		20a. Method of Disposition 1			oosition (Name of ematory or other plac		Date	20c. Location - City	
Him H			4 d Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		*	nity Rus.			Elkridge, Funeral H	
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	Physician /Medical Examiner	Iner	23a. Part1. Enter the disease, or complic shock, or heart faiture. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence to form as a conse	uence of):		ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	dical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
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S,	res thet igned b	by P.	Part II. Other significant conditions con	tributing to death but not result	ulting in the	underlying cause giv	ven in Part I.			to the cause of death?
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Division of Vital Records, P.O.	i or Atte after des Directo	Certification;	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At ho building, etc. (Specify	me, farm, s	street, factory, office		28f. Location (S City or Tox		Rural Route Number,
6	To the Hospital or Attending Physicism: The law within 24 hours after death. To the Funerell Director: After this certificate hes completely filled in by the funeral director, page 2.	Medical C	29a. Certifier (Check only one) Certifying Phys	ician: To the best of my kno ter: On the basis of examinal and manner stated.	wledge, de tion and/or	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manner date and place, and	as stated. due to the cause(s)
	To the within To the comp	X	29b. Signature and little of certifier			29c. Licens	se number		29d. Date signed (M	onth. Day, Year)
7	x1		1/1			RE	50000		5-25-	06
Ì	014		30. Name and address of person who co Innocent Monya-Tar	mbi 9000 F	rankl	e, Print)			e, MD 2123	7
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	E)				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 19, 2006 **Physician** 6:00 AM M Chris D. Farmer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Beverly Health Care Center Hagerstown | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (5 April 1 1, 1974 | Hawali 7. Age (In yrs. last birthday) 32 Yrs. 9. Birthplace (State or Foreign **Funeral** 215-15-9557 1 □XM 2 □ F Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-1 show other treumetic event, the MacAcal Experience rulet be mailified at Maryland 1 Yes 2 No Washington Hagerstown Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 300 F North Colonial Drive 21742 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: White ρ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than any injury or other treumetic event. If a Mental injury or other treumetic event. College (1-4or 5+) Elementary/Secondary (0-12) College Student 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas D. Farmer, Sr. Kenni L. Shaw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ms. Kenni L. Shaw, mother 300 F North Colonial Drive, Hagerstown, MD 21742 20b. Place of Disposition (Name of cometery, crematory or other place)

Mt. Zion Lutheran Cemetery May 23, 2000 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Frederick, MD 21. Signature of Funeral Service Licensee ²²Keeney and Basford PA Funeral Home MO0255 21701 106 East Church St., Frederick, MD 23a. Part1. Enter the disease, or complications that prused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 12 years Immediate Cause (Final Traumatic Brain Injury with Vegetative State Physician disease or condition resulting in death) /Medical **Examiner** 12 Years Recurrent Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 □ No should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4X Unknown 1 ∏ Yes 2 ☐ No Completed peen 24a. Was an autopsy performed? 1 ☐ Yes ②☑ No 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate 1 ☐ Yes 2 X No Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 Aug. 20, 1994 To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director; After thi completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 12:15_M AM 5 Pending 1 Natural passenger ejected from vehicle 1 ☐ Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Roadway 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Mt. Phillip Road, Frederick, 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fitle of certifier MAY 26, 2006 00076965 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 251 J. Steple-31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2006 MAY 3 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year Physician JANET WATERS FLAGLE MAY 29 2006 02:00aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BLAKEHURST TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/2/1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F MARYLAND 003-20-2769 78 Yrs. Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland of Mental Hyglene.
marked other then "natural", or Iteme 23a or 286-1 ehow 10c. City, Town or Location 10a State 10d. Inside City Limits Item 27 is marked other then "natural", or iteme 23a or 28e-f ehow other traumatic event, the Middical Examinar must be publified at 1 Yes 2 No BALTIMORE TOWSON Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 1055 WEST JOPPA RD 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) VOLUNTEER VOLUNTEER permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked other any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HENRY H. WATERS JANET LEVY ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1055 WEST JOPPA RD TOWSON, MD. 21204. CHARLES D. FLAGLE(HUSBAND) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Melhod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) THE REDEEMER 06/05/06 OF CH. BALTO. CITY, MD. 22. Name and Address of Facility
HENRY W. JENKINS & SONS C
16924 YORK RD MONKTON, MD. 21. Signature of Euneral Service Licenses SONS CO. 21111 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediale Cause (Final BREKS7 CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 🎺 Due to (or as a consequence of): ettending physicien a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 8 1 Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes autopsy performed? Yes 2 No certificete 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) ို 1 ☐ Yes 2 DNo this After thi 28b. Time of 28a. Dale of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification; 5 Pending investigation 1 Najural 1 ☐ Yes 2 ☐ No М 2 Accident Director: 6 Could not be determined 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours of To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ellugleenn 2006 30. Name and address of pe on who completed cause of death (Item 23a) (Type, Print) IGLEHART M.D. 6301 N. CHARLES ST. BALTO.MD. IREDELL W. 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

ORIGINAL

Maurice Furlong Ir

Please Type or Print in Black Indelible Ink

State of Maryland	/ Departme	ent of Health	and Me	ental Hygien

naunce Fullong, .	1	For State Cristrar Certification	ficate of Death		g. No. 200	5 1695
Physiciar Medical Examin	n/	Decedent's Name (First, Middle,Last) Maurice Bennett Furlong Jr		2 Date of Death Month May 27, 20	Day Year	Time of Death 1644 hrs
Marin Star		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of		4c. County of Death	
Funeral	4	3807 St. Paul Street 5. Social Security Number 6. Sex 7. Age (In yrs last	birthday) If Under 1 Year If Under	24Hrs. 8. Date of Birt	N/A n(MM/DD/YYYY) 9. Birth	place (State or
Director		127-34-6530 1XXM 2□F 63	Yrs. Months Days Hours	Min. 02/10/	1943 Foreign	try) New York
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location			Od. Inside City Limits
Maryland 28a-f show 1 at once.	į	3	altimore		g. Citizen of What Countr	Yes 2 No
th the Mary 23a or 28a notified at	<u>D</u>	10e. Street and Number 3807 St Paul Street	10f. Zip Code 21218	10	USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No	If Yes, specify Cuban, Mexican,		White, etc.	
nrs after ural", uminer	출.	3 Widowed 4 Divorced if Yes, Give Year 171 - 174 or Dates. 15. Decedent's Education (Specify only highest grade completed) 11	1 Yes 2 No specify: 6a Decedent's Usual Occupation (Give k		Specify Whit 16b. Kind of Business/Inc	
5 72 hou un "nat gal Exa	활	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT	use retired)		
5-0036 led within 72 hours aft tygiene "hours aft tygiene "hatural" to there than "natural" the Medical Examina	Completed	17. Father's Name (First, Middle, Last)	Pathologist	s Name (First, Middle, M	Medical C	<u>enter</u>
21215-0036 Juld be filed within 7 I Mental Hygiene. marked other than	8	Maurice Bennett Furlong Sr	ŀ	Helen Veron	ica Carey	
MD 21 2 should th and Me 27 is ma umatic ev	- 1	19a Informant's Name/Relationship (Type, Print) Conchita Co Hong Wife	19b. Mailing Address (Street and Numl 3807 St Paul Street		e, Maryland	21218
Baltimore, MD 2121 pemit, Pages I and 2 should be fi Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event,	I	1 X Burial 2 Cremation 3 Removal from State St. M	nce of Disposition (Name of cemetery, imatory or other place) ary's Cemetery	Date 6/1/06	20c. Location - City or To Baltimore,	
Baltimo permit. Page Department Important: injury or ot		Donation 5 Other Specify: Signature of Fungra/Service Licenses Dimis X La Lu Konakis	22. Name and Address of Facility		Mefeld Funeral More, Maryland	
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/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Head Injuries Due to (or as a consequence of):				Death
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760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED				
760 ficate b g physic s the bus		IF FEMALE. 23b. Was decedent pregnant in the 23c. If yes, outcome of pregna	0	pregnancy	23d. Date of delivery Month Da	y Year
of Vital Records, P.O. Box 687 ing Physician: The law requires that the death certific After this certificate has been signed by the attending I tuneral director, page 2 should be detached for use as the state of	Physician/	past 12 months? 4 Pregnant at time of deat		programay		,
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Reco	mo _S				med? death? 2 ✓ No 1 Yes	2 No
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n of Vital Rec Jing Physician: The I After this certificate I	ا: T	27. Manner of Death 28a. Date of Injury 28d. Worth, Day, Year)	28c Injury at Work	Subject fell t	ow injury occurred hrough attic floor	
Sion Attendideath ctor: /	atio	2 Accident Investigation May 27, 2006	FOUND: 1 Yes 2 🗸	No -		I De la National Cons
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death and the rest ifficate has been signed by led in by the funeral director, page 2 should be detach.	Certification	3 Suicide 6 Could not be determined (Specify) Single Fami	ne, farm, street, factory, office building, etc ly Home	or Town, St	treet and Number or Rura rate) ul Street, Baltimore,	
hou hou	Medical Co	29a Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination and	death occurred at the time, date and pla	ce, and due to the cause	e(s) and manner as started	t i
To To com	Med	and manner stated. 29b. Signature and title of certifier.	29c. License number		29d. Date signed (Monti	n, Day, Year)
		1 / Mm	O.C.M.E.		May 28, 2006	
13		30. Name and address of person the completed cause of death (Item 2 Mary G. Ripple MD. Deputy Chief Medical Exam	,	ore, MD 21201		
	ate	31. Date filed (Month, Day, Year) 32. Red Strar's Signature MAY 3 1 2006	y have			
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_			1 - Stata Registrar			Cei	rtificate c	of Death		Reg. N	<u> </u>	16954
	Physici	an	1. Decedent's Name (First, Middle,	Last)			Drady		2. Date of I	Death Di	ay Year	3. Time of Death 3.33.9 M
1 m	/Medic Examin		4a. Facility Name (If not institution,	give street and nui	mber)			n, or Location of		4	0, 200 c. County of Dea	<u> </u>
A	LXdiiii		Bon Secours Hos	spital			Baltin	nore				
W	Funeral			3. Sex 1 ☐ M 2 🔯 F	7. Age (In yrs.		If Under 1 Ye Months Da		Min. (Month,	Day, Year	9. Bi	rthplace (State or Foreign ountry)
	Director		219-20-8398 Usual Residence of Decedent		88	3 115.			Apr 9	. 19	18 Mai	yland
	how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
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	with th		10e. Street and Number	A			10f. Zip Cod				itizen of What C	ountry?
	me 23	Funerai	1100 Edmondson	12. Was Dece	edent Ever in U	I.S. 13.1	212: Was Decedent		gin? (Specify Yes or I	USA	14. Race - Am	
9	or Ita	/ Fur	1 ☐ Never Married 2 🔀 Marrie	Armed Fo d 1 ☐ Yes If Yes, Giv	2 🔀 No		nt Yes, specify C 1 ☐ Yes 2 🖾 I		, Puerto Rican, etc.)		Black, Wh	te, etc.
003	n 72 hours after death with the Maryland "natural", or Itame 23e or 28e-1 ehow igical Exeminant be notified at	d by	3 Widowed 4 Divorced	Year or D	ates:					4.01		ack
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Maryland 21215-0036	0 0 0	Be	17. Father's Name (First, Middle, La						r's Name (First, Midd		n Sumame)	
7	should nd Men marke umatic	J.	James Henry Coa 19a. Informant's Name/Relationshi			19b. Mailir	ng Address (Str		a Ann Chas or or Rural Route Num		or Town State	Zin Codel
	nd 2 shoalth and 27 is m		Deborah Grady/d						Blvd. #B E			
ore,	ges 1 and 2 should it of Health and Mer if Item 27 is marke or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	. □Bemoval from		Place of Dispo	sition (Name of natory or other	. !	Date	_	ocation - City or	
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Bal	permit. Pages Department of Important: If I eny Injury or once.		21. Signa un Funeral Sprice Li		injerto	S	Name and Ad tate An altimor	atomy B	oard 655 V	V. Ba	ltimore	Street
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68	tificate ig phys as the	g		0						-		
Вох	ath cer tendin or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, out 1☐Live b	come of pregna		Ectopic pregna	incy			23d. Date of de Month	livery Day Year
0.	The law requires that the death certifica tte hes been signed by the ettending ph tage 2 should be detached for use as th	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregn 9☐Unkno	ant at time of d	leath 5⊡	Other (specify)			World	Day
۵.	es that igned by be deta	by Ph	Part II. Dther significant condition	s contributing to de	eath but not res	ulting in the ur	nderlying cause	given in Part I.	23e. Dio	tobacco	use contribute t	the cause of death?
ord	w require been sig should b								1	Yes 2	¶ Z No 3□P	robabły 4 Unknown
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alF	10	e Col	OF Man area referred to medical						1 ☐ Yes		death?	2 □ No
Ξ	Physician: this certific ral director,	0 8	25. Was case referred to medical examiner? 1 ☐ Yes 2 🐼 No	Hospital:	npatient 2	ER/Outpatien	t 3 DOA	Other	of Death (Check only rsing Home 5 - Re		6 MOthor (Sac	offet
n of	ng Phy Iter thi neral	J: L	27. Manner of Death 1 Natural 5 Pending	28a. Date		28b. Time of Injury	28c. Ir	njury at Nork?	28d. Describe			cny)
sio	Attending r death. ector: Afte by the fune	catio	2 Accident investiga 3 Suicide 6 Could no	the -				Yes 2 n				
Division	el or At after of Direct d in by	Certification;	4 Homicide determin	ed 286. Place	of Injury - At h	ome, farm, str (y)	eet, factory, offi	Ce	28f. Location City or T	(Street ai own, Stati	nd Number or R e)	ural Route Number,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier 1 Certifying (Check only open)	caminer: On the ba	best of my kno asis of examina ner stated.	owledge, death	n occurred at the vestigation, in m	e time, date and ly opinion, deat	d place, and due to the	e cause(s e, date an) and manner as d place, and due	s stated. to the cause(s)
	To th To th comp	M	29b. Signature and title of certifier	N. 1 - 1	160.0	212	29c. Lice	ense number		29d. Da	ate signed (Mont	h. Dey, Year)
				Medical	Truse	U TCe.	U	47148		Mai	11201	2006
			30. Name and address of person w	NO ZO	O West	Balt N	1072 ST	treet,	Baltimore	M	siryland	21223
	Sta Registr		31! Date filed (Month, Day, Year) MAY 3 1 200	32. R	egistrar's Signa	ature				*	l	

			_ For	State of Maryl	and / Departmo		and Mental Hy	giene	LCOEE
			1 - State Registrar		Certific	ate of Death		Reg. No. 4 UUD	0900
	Physici /Medic		1. Decedent's Name (First, Middle, Las	ARR	GREEN	wood	2. Date of De. Month	The 2006	3. Time of Death 3.55A M
	Examin		4a. Facility Name (If not institution, give	street and number)	Parton 4b.C	ity Town, or Location of	f Death /	4c. County of Deat	1A
	f		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday) If Un	der 1 Year If Under 2	24 Hrs. 8. Date of Birt	th 9. Birt	hplace (State or Foreign
	Funeral Director		220-30-3442 Usual Residence of Decedent	7. Age (In)	Yrs. Mont	hs Days Hours	8. Date of Bin (Month, Da 05/18/3		Maryland
	yland	}	10a. State 10b. County	10c	. City, Town or Location				10d. Inside City Limits
	e Mar	ctor	MD Baltim	ore	Baltimore				1 Yes 2 No
	with th	Director	10e. Street and Number		10f.	Zip Code		10g. Citizen of What Co	untry?
	e 23e	erai	2582 Malbourne Ave	. Baltimore		21223	nin? (Specify Ves or No	USA - 14. Race - Ame	rican Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Heath and Mental Hyglene. Depertment of Heath and Mental Hyglene importants if item 27 is marked other than "naturel", or items 23a or 28a-f show stry injury or other treumatic event, its Medical Exaciliar must be notified at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 1 Yes 2 10-10-11 Yes, Give Year or Dates:	23/56 1 Yes	s 2 No Specify:	gin? (Specify Yes or No , Puerto Rican, etc.)	Black, Whit Specify: Whi	e, etc.
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7	withii liene. r then	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Pipe Fit			Enginee	ring
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ylar	should b nd Ments marked umatic e		Harry Carr Greenwo	od		Louis	se Marie U	Inknown	
Maryland	and 2 sho ealth and n 27 ie m		19a. Informant's Name/Relationship (Rita Joan Greenwo		_			er, City or Town, State, 2 e Maryland	
Baltimore,	Pages 1 a nent of He int: if item iry or othe		20a. Method of Disposition 15 Burial 2 Cremation 3 C 4 Donation 5 Other (Specific	Removal from State	b. Place of Disposition (cemetery, crematory oudon Park	Name of or other place) Cemetery (Date 05/31/06	20c. Location - City or Baltimore	
Balti	permit. Depertmental finportal eny inju		21. Signature of Fuheral Service Licer	see				k Funeral H e Maryland	
			23a. Ratt. Enter the disease, or corn slock, or heart failure. List only	plications that caused the cone cause on each line.	death. Do not enter the r	node of dying, such as	cardiac or respiratory as	rrest,	Approximate Interval Between
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	s that i ned by e deta	by Ph	Part II. Other significant conditions of	ontributing to death but not	resulting in the underlying	g cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
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ital	ion: rtifica ctor, p	Bec	25. Was case referred to medical examiner?			26. Place	of Death (Check only of		
> >	hysic this ce	2	1 ☐ Yes 2 Ø No	1				dence 6 ☐ Other (Spe	city)
UC C	Jing P	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ N		now injury occurred	
Division of Vital Records,	or Attending after death. Director: After in by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	-	At home, farm, street, fac			Street and Number or Ru vn, State)	ral Route Number,
	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medicai Co	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exar and manner stated.	knowledge, death occur mination and/or investiga	red at the time, date and tion, in my opinion, deat	d place, and due to the th occurred at the time,	cause(s) and manner as date and place, and due	stated, to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier			29c. License number		29d. Date signed (Monti	
			> Kerri Vi	ssell.	MD	P18604		5-26-2	006
	P		30. Name and address of person who	completed cause of death	(Item 23a) (Type, Print)	PNR 5+R	eet Baltic	5-26-2 nory MD a	2120/
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature Apple				

06-03586 Please Type or Print in Black Indelible Ink James Gilyard State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 27, 2006 0858 hrs Medical Examiner 4b. City. Town, or Location of Death 4a Facility Name (if not institution, give street and number, 4c. County of Deat **Balimore City** Saint Agnes Hospital 5. Social Security Numbe If Under 1 Year | If Under 24Hrs. 6. Sex 7. Age (In yrs last birthday) 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State of **Funeral** Foreign Country) Hours South Director 1 X M 2 Usual Residence of Decedent 10a. State 10b County 10d Inside City Limits Md 1 X Yes 2 No 23a or 28a-f show notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Numbe 10g. Citizen of What Country Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U S 14 Race - American Indian, Black Armed Forces? White, etc. Never Married 2 Married 2 X No Yes Yes, Give Year Divorced Yes 2 No specify: Specify. ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than " 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Sur Be If item 27 is marked and Mental 2 me/Relationship (Type 19b. Mailing Address (Street and Number of Route Number, W Department of Health 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Cremation 3 Removal from State Donation 5 Other Specify Physician disease, or compli callied the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED If yes, outcome of pregnancy 23c 23d. Date of delivery 23b Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Part II. Other significant conditions o contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? þ Records, P. 1 Yes 2 No 3 Probably 4 V Unknown Chronic Alcoholism Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes 2 No the Hospital or Attending Physician: 25 Was case referred to medical 26.Place of Death (Check only one) of Vital Be Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 DOA After this 1 🗸 Yes 5 28a Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Division ✓ Natural Yes 2 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c License number 29b Sonature and title of 29d. Date signed (Month, Day, Year) O.C.M.E May 28, 2006 a 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY Registrar

DHMH 17 Rev 1/2001 OCMF 2006 06-03618

Richard Llovd Givler

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Maryland / Department of Health and Mental Hygiene

dicitatu Lioyu G		State t I- For State Registrar	or Maryland / Depa <i>Cer</i>	rtificate of Death	na Mentan	-	g No 2 N	06 1695
Physicia	an/	Decedent's Name (First, Middle,Last)				2. Date of Death Month May 28, 20		3. Time of Death 0545 hrs
Medical Exami		Richard 4a Facility Name (if not institution, give		vler	or Location of Deat		4c. County of De	
		8267 Quarterfield Road	,	Severn			Anne Aruno	
Funeral		Social Security Number 6. Sex	7. Age (In yrs la				h (MM/DD/YYYY) 9.	Birthplace (State or reign
Director		217-86-1216 ¹ X	M 2 F 44	Yrs. Months Da	ays Hours Mi		0, 1961	Country) Japan
any	F	Usual Residence of Decedent 10a. State 10b. County	I10c City	Town or Location				10d Inside City Limits
* .								1 Yes 2 X No
ne Maryland or 28a-f show fied at once.	흃	Maryland Anne Aru 10e Street and Number	nder	Severn 10f Zip Code		10	g Citizen of What C	Country?
ith the M 23a or 2 notified	ä	8267 Quarterfield	Road	211	.44		United	States
15-0036 filed within 72 hours after death with the Maryland Hygiene of other than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces?	S. 13 Was Decedent of H If Yes, specify Cub				merican Indian, Black,
er dear		3 Widowed 4 Y Divorced	1 Yes 2 X No	1 Yes 2X N	In specify		Specify:	White
urs aft tural" amine	g p	15. Decedent's Education (Specify onl	or Dates:	16a. Decedent's Usual Occup	pation (Give kind of		16b. Kind of Busine	
5-0036 led within 72 hours after tygiene other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working li	fe DO NOT use re	tired)		
5-0030 lled within Hygiene I other the	ğ,	12th 17. Father's Name (First, Middle, Last)		Contract		ne (First, Middle, M		Company
21215-0036 Auld be filed within 7 Mental Hygiene marked other that c event, the Medics	Be C		.vler		Nancy		Isaacson	
MD 212 12 should by th and Ment 127 is mark umatic ever		19a Informant's Name/Relationship (Ty		19b. Mailing Address (Str				tate, Zip Code)
0		Nancy L. Givler/mo		300 Windfern				yland 21108
Baltimore, MD 21 ocenit. Pages I and 2 should Department of Realth and Me Important: If item 27 is ma injury or other traumatic ev		20a Method of Disposition 1 Burial 2 X Cremation 3		Place of Disposition (Name of or prematory or other place)	cemetery,	Date	20c. Location - City	or Town, State
timent trant: rtant:		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licens		t Arundel Crem				, Maryland
Baltimore permit. Pages 1 g Department of Hd Important: If it injury or other t		Aug H. QUA	. /	22. Name and Addre Donaldson 1411 Annap	Funeral	Home &	Crematory	, P.A.
Physician		23.1 art I. Enter the disease, or compliante. List only one cause on each		Do not enter the mode of dyin	g, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	- 1	Immediate Cause (Final disease a	Ethanol and mixed	d drug (Exycocdone	e and diaze	pam) intox	ication	Death
		b	due to (or as a consequence of	f):				
	ner	Sequentially list contuitions,	ue to (or as a consequence of	f):				
	Examiner	(Disease or injury that initiated C.	Oue to (or as a consequence of	f):				
ecuted and transit		d		0 07 00 6 14	5056 6 lo lo			
60, ate be exe obysician re burial -	Medical			3a,27,28a-f,perME	,G856,6/8/0 	6 TT		
876 tificate ng phy as the	-	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preging 1 Live birth	-	Ectopic pregn	nancy	23d. Date of deliver Month	very Day Year
Box 687 e death certific the attending p	sician	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of de					
O. Bc it the der Iby the a	Phy	Part II. Other significant conditions	9 Unknown	esulting in the underlying cause	e given in Part I.	23e Did tol	pacco use contribute	to the cause of death?
of Vital Records, P.O. og Physician: The law requires that th therefore this certificate has been signed by neral director, page 2 should be detach	\$		o de la companya de l			1 Yes	2 No 3 F	Probably 4 🗸 Unknown
ords, w requir s been s should 1	letec					24a. Was a		autopsy findings available to completion of cause of
eco he law ate has	Completed					perform	ned? death	1?
tal Rec	Be	25. Was case referred to medical		26.Pla	ce of Death (Check			
A sie ig sie ig eige ig ig ig ig ig ig ig ig ig ig ig ig ig	To B	1 Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient 3 DOA			Residence 6 🗸 Of	ther, Scene
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Division tall or Attendi	icati	2 Accident Investigatio	28a Place of Injury - At he	Fnd 5:30 am 1 1 come, farm, street, factory, office		unk 28f. Location (S	treet and Number or	Rural Route Number, City
Division Hospital or Attem 24 hours after death : Funeral Director:	Certification:	3 Suicide 6 X Could not be determined		esidence		Severn, A	_{ate)} 8267 Quai nne Arundel,	Rural Route Number, City Terfield Road MD
Division of Vital Records, P.O. Box 68760, To the Hospital or thrusting Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		Olicon of my		ge, death occurred at the time,				
To the Howithin 24 F. To the Funcompletely	Medical	2	and manner stated	nd/or investigation, in my opinion	nse number	at the time, date a	29d Date signed (
	2	29b Signature and title of certifier	Pappo		D.M.E.		May 28, 2006	would, bay, 1901/
		30. Name and address of person who c	ompleted cause of death (Item	·				
		Patricia Aronica-Pollak MD			Street, Baltimo	re, MD 21201		
	tate		32. Restrar's Signatu	K Snack				
Regis	uar	MAY 3 1 2	006 Blown	Va Valvanda				

Please Type or Print in Black Indelible Ink

Villam B. Good		1- For State Registrar Certificate of Death Reg No. 2006	95
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 3. Time of Death Month Day Year 1125 hrs	
ere.		WILLIAM H. B. GOODWIN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
		Keswick Care Center Baltimore	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of 8irth (MM/DD/YYYY) 9. 8irthplace (State of Months Days Hours Min. 05/13/1916 Country) MD	
	ŀ	212-16-8985 1 M 2 F 90 Yrs.	•
w any		10a State 10b. County 10c. City, Town or Location 10d Inside Cit	
Aaryland 28a-f show 1 at once.	햦	MD BALTIMORE 1 Yes 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	No
ith the Mar 23a or 28 notified a	Director	700 WEST 40TH STREET 21211 USA	
th with tems 23 at be no	Funeral	11. Marital Status 1	ck,
ter dea		1 Yes 2 No 3 Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 1 Yes 2 No specify: 1 Yes 2 No specify:	
hours afte	g b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	
36 in 72 h han "n Jical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 4YRS COLLEGE ADMINISTRATOR ADMINISTRATOR	
5-0036 Jed within 72 Hygiene to ther than '	Som	17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname)	
21215-Culd be filed vomental Hygismarked oth	Be	WILLIAM H.B. GOODWIN EDNA LOUISE	_
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene nt: If item 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Medical Examiner must be notified at once	T	19a Informant's Name/Relationship (Type, Print) ALBERT GIGEL(EXECUTOR) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2906 GRINDON AVE #3 BALTO., MD. 21214.	
imore, MD 2 Pages I and 2 shou ment of Health and N lant: If item 27 is n or other traumatic		20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
Baltimore, permit Pages I ar Department of Hee Important: If ite		GREEN MOUNT CREMATORY 05/30/06 BALTO CITY	, MD.
Bal permi Depa Impo	-	21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MD. 21111.	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Between On:	set and
Examiner		Immediate Cause (Final disease or condition resulting in death) a Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	1
No.		Sequentially list conditions, b.	
	nine	If any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated c.	
√g a _ is	Examiner	events resulting in death) Last Due to (or as a consequence of): d.	
to, e be executed ysician and burial - transit	Medical	UNPENDED AMENDED	
760, frate be physical the burn		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	
Box 687 e death certifif the attending	sician	past 12 months? The print 2 Fetal death 5 Cither (Specify) Month Day Yes	ar
Bo)	Physi	1 1 Ves 2 No 9 Unknown	
res that the signed by	ङ	1 Yes 2 No 3 Probably 4 Link	
ords, w require s been sig	Completed	24a Was an 24b Were autopsy findings a	vailable
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ital Rec ician: The sertificate rector, page	Be Co	25. Was case referred to medical 26. Place of Death (Check only one)	No
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Division of Vital Records, P.O tat or Attending Physician: The law requires that t is after death al Director. After this certificate has been signed by led in by the funeral director, page 2 should be detaced.		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 22b. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No	
Divisior pital or Attencours after death eral Director: filled in by the	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number)	er, City
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To To com	Mec	and manner stated 29b Signature and title of tertifier 29c License number 29d Date signed (Month, Day, Year)	
		O.C.M.E. May 27, 2006	
	1	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
St	ate		
Regist			

			For Stata Registrer	St			d / Depa		t of H	ealth a		ental Hy		ie	5	160	E. O.
	Physicia	an	1. Decedent's Name (First, Mic Richard E1	dle, Last) Sworth	Gi1mc)re						2. Date of De Month	C	ay Y	ear	3! Time of De	
	/Medic	al						45 005	T	1		May	28	2006	Do-Ma	3:27p	М
	Examin	er	4a. Facility Name (If not institut 5554 Moriar	-				Elde		Location o	i Death		-	c. County of Carro			
	Funeral		5. Social Security Number	6. Sex	7. Ag	je (in yrs. i	last birthday)	If Under Months	1 Year	If Under 2	24 Hrs. Min.	8. Date of Bi (Month, D	rth	9	. Birth	place (State or F	oreign
	Director		172-46-1402	1 X M	² 53	3	Yrs.	Months	Days	Hours	Min,	Apr 21	19	53	PA_		
	and wo		Usual Residence of Decedent 10a. State 10b. Cour	ity		10c. City	y, Town or Lo	cation				·				10d. Inside City	Limits
	Many I-f sh	tor	Md Carr	011		E1de	ersbur	g								1 🗌 Yes 2	X No
	h with the 23a or 28a at be not	Funeral Director	10e. Street and Number 5554 Moriarty	Court				10f. Zip 217					10g. (itizen of Wh USA	at Cou	ntry?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importents: If item 27 is marked other then "neturel", or Items 23a or 28a-f show entry injury or other treumatic event, it is Medical Eventil at most be rediffed at ODGE.	by Funer	11. Marital Status 1 □ Never Married 2 ☼ M 3 □ Widowed 4 □ Divorce	arried 1	/as Decedent med Forces? ☐ Yes 2√ Yes, Give A ear or Dates:	?	I	Vas Deced f Yes, spec			gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Black, Specify:	White,	etc.	
21215-0036	72 hou	Completed by		ent's Education	1	- 5	16a. Deced	lent's Usua	l Occupa	ation	of worki	na	16b.	Kind of Busi	ness/in	dustry	
215	ithin 7 ne.	nple	Elementary/Secondary (0-12		ollege (1-4or	5+)	Syste	ns Sa	e retired 1 e.s	luring most) Manae	er	19	D.	lastic	S		
land 21	id be filed wental Hygier ked other ti c event, tr	To Be Co	17. Father's Name (First, Midd. William J. Gi	e, Last)	⊦5 Jr.		0,000			18. Mothe	r's Name	(First, Middle Patton	, Maide				
Maryland	nd 2 shoul ilth and Mi 27 Is marl r treumati	ř	19a. Informant's Name/Relation Greta Ann Gilm									Route Numbersburg				Code)	W
Baltimore,	Pages 1 arent of Heanut: If Item		20a. Method of Disposition 1		val from State	, c	Place of Dispo emetery, cren Hill (natory or o	ther place	e) (5/3/2	eate 2006		Location - Ci ndy La	•	own, State Twnshp,	PA
Balti	permit. Departm Importe eny inju		21. Signature of Funeral Servi	ce Licensee	ubert							ht Fun ille,			&	Chape1	
	Physician /Medical		23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	or complicatio ist only one ca a		ine.	ecAa	e he mod	of dying	g, such as NGJ	cardiac o	r respiratory a	irrest,			Approximate Interval Betwee Onset and Dea	
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Y	cuted nd ransit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Unsage on just that initiated events	፟፟፟፟፟፟፟፟፟፟፟፟፟፟፟፟፟፟፟፟፟፟፟፟፟፟	Due to (or as	a consequ	uence of):										
68760,	sate be executed oblysician and the burial-transit		resulting in death) Last	d	Due to (or as	a consequ	uence of):					· · · · · · · · · · · · · · · · · · ·					
P.O. Box 6	The law requires that the death certificate be executed the tas been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ You get Unknown	1 4	yes, outcome □Live birth □Pregnant a □Unknown	2 Fetal	Ideath 3□	Ectopic pr Other (sp						23d. Date of Month		ery Day Yea	ar
	quires that n signed t uld be det	by	Part II. Other significant cond	itions contribu	ting to death t	out not resi	ulting in the ur	nderlying ca	ause give	n in Part I.				~		he cause of dea pably 4 □Unk	
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Vital	Physicien: this certificatal director,	To Be	25. Was case referred to medi examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	Hospi	tal: 1 □ Inpati	ent 2 🗆	ER/Outpatien	t 3 🗆 DO	A Othe	. 61		(Check only		6 Other	(Snecil	iv)	
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	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical Certification:	29a. Certifier 1 Certif (Check only one) 1 Certif	ying Physicia el Examiner:	n: To the best On the basis of and manner si	of examina	wledge, death tion and/or inv	occurred estigation,	at the tim in my op	ie, date and pinion, deat	d place, a	and due to the ed at the time,	cause(date a	s) and mann nd place, and	er as s I due to	tated. the cause(s)	
	To the within To the Comp.	M	29b. Signature and title of cert	great of the state	led	M.	D.	29c	License	number 0 5 4	-91		29d. D	ate signed (Month,	2006	
_	6		30. Name and address of pers	on who comple	exli	Ch	n 23a) (Type,	Print) (N.	BEL	rede	THE A	VE	BAH	îMi	INE MD	21219
	Sta Regist		31. Date filed (Month, Day, Ye		32. Regist	rar's Signa	iture	best	9					1			

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) Year **Physician** VINTON ERNEST GROOMAN, JR. 10:10 a^M May 27, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12509 Cedarbrook Lane Prince George's Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 7, 192 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Yrs. Director 216-44-8907 1928 Connecticut Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

Wher than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yes 2 No Director MD Prince George Laurel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12509 Cedarbrook Lane 20708 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. other traumatic avant, the Madical Examiner 1 XYes 2 No If Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 XNo Specify: 2 3 Widowed 4 Divorced Year or Dates: 1951-53 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Cryptanalyst Government it and 2 should be filed w Health and Mental Hygier tem 27 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vinton Ernest Grooman, Sr. Viola Terwilliger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Randall Grooman /son 12900 Eagle Creek Dr., Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō = 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State permit. Page Department of Important: If any injury or once. June 2, 06 Southington, CT 4 ☐ Donation 5 ☐ Other (Specify) Oak Hill Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** Prostate cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine ng physician and as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 X No 1 Yes 2X) No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred the Hospital or Attending Phin 24 hours after death. 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C to the basis of examiner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3012 D4501L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8343 Cherry Lane, Laurel, Maryland 20707 Isabella Martire, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760

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Records.

Division of Vital

			For State Registrar	State of M	laryland		artment of	Health and If Death	Mental Hy	giene Reg. No.	006	16961
			1. Decedent's Name (First, Midd.	e, Last)					2. Date of De Month	aath Day	Year	3. Time of Death
	Physici /Medio		Rita Heiger						May 21	, 2006	1041	05:50 PM
	Examir		4a. Fecility Name (If not institutio	n, give street and number)		4b. City, Town	n, or Location of De	ath	4c. Co	unty of Death	
			Manor Care of	Joppa			Towso	n		Ba1	timore	
	Funeral		5. Social Security Number		ge (In yrs. las	t birthday)	If Under 1 Ye Months Da	ar If Under 24 H		th		lace (State or Foreign
п	Director		217-14-1530	1□M 2⊠F	85	Yrs.	WIOTHITIS Da	ys Hours W	Feb 20,		Maryl	,,
	pu ,		Usual Residence of Decedent		10-07-7	F						
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	ith the Marylan or 28a-f show	cto	MD Balti	nore	Luthe	rvil]						
	or 24	Funeral Director	10e. Street and Number				10f. Zip Cod	θ		10g. Citizer	of What Cour	ntry?
	23a	ra	1414 Front Ave				21093			USA		
	after dea or Items	ıne	11. Marital Status	12. Was Deceden Armed Forces	?	13.	Was Decedent of If Yes, specify C	of Hispanic Origin? Juban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	o- 14.	Race - Americ Black, White,	
36	or II	Y F	1 Never Married 2 Mar	If Yes, Give			1 ☐ Yes 2 🎛 f	No Specify:		Sp	ecify:	
215-0036	n 72 hours after death with the Maryland "neturel", or Items 23a or 28a-f show idical Examirer: "ust be nutified at	d by	3 Widowed 4 □ Divorced							32	whi	
5	"net	ete		nt's Education est grade completed)		(Give	dent's Usual Oc kind of work do DO NOT use rei	ne during most of v	vorking	16b. Kind	of Business/In	^{dustry} unk
12	within lene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or	·			1180)				
121	should be filed within and Mental Hygiene. marked other than imatic event, the Mental Mental and the Mental and Mental an		12 17. Father's Name (First, Middle,	(ast)		BOOK	keeper	18 Mother's N	lame (First, Middle	Maiden Su	mame)	
anc	ntal hed	Be	Joseph Aloysiu									
Ž	should nd Men marke umatic	10	19a. Informant's Name/Relations			10h Maili	na Address (Str	parbara eet and Number or	Margaret			Code)
Maryland	12 s h ar 7 ls treu		Julian Lapides		5							
	1 and 2 Health tem 27		20a. Method of Disposition	/ lawyel	20b. Plac	e of Dispo	sition (Name of	Suite 33	2 Baltimo		ion - City or To	
٥	ages trit or o		1 Burial 2 Cremation	all and	e cem	netery, cre	matory`or other	olace)			•	
Baltimore,	rtmer rtent rtent njury		' 4 ⊠Donation 5 ☐ Other (3			20	Name and Ad	dress of Facility				
Bal	permit. Pages 1 and Department of Healt Importent: if item 2 any injury or other once.		Ronald		gector	Ş	tate An	atomy Bose, MD 212	rd 655 W	. Balt	imore S	Street
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			shock, r heart failure. Lis	only one cause on each	line.							Interval Between Onset and Death
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	/Medical Examiner		,	Due to (or à	s a consequer	nce of):						
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×	certif iding ise a	W.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnanc	y				23d	. Date of delive	PLA
Вох	death e atter ed for u	ciar	in the past 12 months?	1 ☐ Live birth			Ectopic pregna Other (specify				Month	Day Year
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Records,	w requires that been signed by should be det	Completed by	end-stare	Lennen	uti'a				1 🗆	Yes 2□N	lo 3 Prob	ably 4 Minknown
Ö	v req beer shou	ete	9						24a. Was	an 2	4b Were auto	psy findings available
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of		To.	27. Manner of Death		tient 2 EF	8b. Time o	IL SU DOM	njury at Nork?	28d. Describe			//
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Division	Attending r death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of In	njury - At home	e, farm, st	reet, factory, offi	се			umber or Rum	I Route Number,
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	Hospitel 4 hours a Funerel iely filled		29a. Certifier 1 Certifyi	ng Physician: To the bes	t of my knowle	edge, deat	h occurred at the	e time, date and pla	ace, and due to the	cause(s) and	d manner as st	ated.
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	To the within 2 To the comple	₩	29b. Signature and title of certifi	ər			29c. Lic	ense number		29d. Date si	gned (Month,	Day, Year)
	F > F 0		· -	1	book	W	7	D411	04	51	211	06
			30. Name and address of person	who completed cause of	death (Item 2	3a) (Type,	Print)			1		•
			Ted Houl	< MM 782	-5 Y	ork	_R27	02W 80	~ M	D	2121	24
	St	ate	31. Date filed (Month, Day, Year	2005 2005	trar's Signatur	гө	west					

Physici	20	- State Registrar Amend Item 1. Decedent's Name (First, Middle, Last)			-,,		2, Date of Deat Month	h Day	Year	3. Time of D	Death
/Medio		Michael W. Hill					05	17	2006	1	A
Examir	er	4a. Facility Name (If not institution, give s	treet and number)	1akel	4b. City, Town, o	or Location of Deat	h		y of Death		
uneral		5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Years)	9. Birth	place (State or	Forei
rector		214-68-5594	^{M 2□F} 50	Yrs.	Months Days	Hours Min.	(Month, Day, Aug 20,	1955	Mary	yland	
show		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocalion				-	10d. Inside City	/ Lim
e de la	tor	MD Wicomio	o Sa	lisbury						1 🗌 Yes	21
or 28,	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cou	ntry?	
23a	rai	7138 Waynewright		11.0	21804			USA	ice - Ameri	een Indian	
item Figure	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	 Was Decedent Ever in Armed Forces? 1 X Yes 2 No 	10.5.	If Yes, specify Cub	Hispanic Origin? (S van, Mexican, Puerl	to Rican, etc.)		ack, White,		
o. Je	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	:	1 ☐ Yes 2 ☒ No	Specify:		Spec	ity: wh t	ite	
natur lical i	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occu	pation during most of world)	rking	16b. Kind of			
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nt th		unk UI 17. Father's Name (First, Middle, Last)	ık	Line	rian	18. Mother's Nar	me (First, Middle, M			2117	
narked of natic svs	To Be	Paul Hill	ister				Lukes Rd			. Mr 21	8
mari	F	19a. Informant's Name/Relationship (Ty)		19b. Maili	ng Address (Street	·	ural Route Number	_			
27 is		Mary Ann Wallace/s	ister	419	St. Lukes	Rd. Fru	itland, M	D 2182	26		
ant: If itsm ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		p. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ice)	Date	20c. Location	- City or To	own, State	
Important: if item 27 is marked other than "natural", or iteme 23e or 28e-f shov any injury or other trsumatic avent, Ita Medical Examinar must be notified at 200s.		4 ☼Donation 5 ☐ Other (Specify) 21. Signiture Funeral Servic License Runal S N	isse Strect	or S	2. Name and Addre	tomy Boar	d 655 W.	Balti	more :	Street	
2 . 0		23a, Part 1, Enter the disease, or compli	cations that caused the di			, MD 2120		est.		Approximate	_
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ed by the ettendir detached for use	by Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	of death 5	Other (specify) _						
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as bee	Completed						24a. Was a autops		Were auto	opsy findings a emptetion of car	vail
page 2 s	Som						perform 1 ☐ Yes 2	ned?	death? 1 ☐ Yes	2 110	
certificete rector, pag	Be	25. Was case referred to medical examiner?	lospital:		100		ath (Check only on	ө)			
this el di	P	1 Yes 2 No	1 Impatient 2	2 ER/Outpatie	nt 3L DOA		lome 5 ☐ Reside			fy)	
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neral Director: A filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	at home, farm, si ecify)	reet, factory, office		28f. Location (St City or Town	reet and Nun , State)	nber or Rur	al Route Numb	ΘΓ,
To the Funeral Director: completely filled in by the	edicai Co	29a. Certifier 1 Certifying Physical Check only 2 Medical Examinate	sician: To the best of my	knowledge, dea nnation and/or in	th occurred at the the threating the threating at threating at the threating at threati	ime, date and place opinion, death occi	e, and due to the ca urred at the time, d	ause(s) and nate and place	nanner as s	stated. o the cause(s)	
To the Fur	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number	2	9d. Date sign	ed (Month,	Day, Year)	
¥ ⊢ 8		Magny Ca	mpleted cause of death (MIS	D	32014		5/17/	06	·	
		30. Name and address of person who co			2-1-1)			1: 1			

DHMH 17 Rev 1/2001

214-168-5594

Michael WHill

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] State Registremend Item #1 Per Phy G856 6 Gentificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Pricilla A. Howard Month **Physician** 10:35 PM May 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** JOHNS HOPKINS BAYVIEW CARE CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Y 09/18/ 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 💢 F 214-14-5070 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State rel', or Items 23e or 28e-f ehow Examinar must be notified at 1 Yes 2 No Directo MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21239 USA 5702 THE ALAMEDA - APT. Completed by Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "naturel" ~ " once. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOME 8TH HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JOHN T. ROSS MAMIE STEWART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR HOWARD/HUSBAND 5702 THE ALAMEDA - APT. A, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK05/25/2006 WINDSOR MILL, MD 21. Signature of Funeral Solvice Licensee 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. 2007 EASTERN AVE., BALTIMORE, MD 21231 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE DEMENTIA Pnysician 17 YEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Box 68760, the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 28b. Time of 1 Natural 5 Pending investigation s after dec. 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours.
the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier icai within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 17747 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopkins Bay over Creele, Bultimore no 21224 13 same 5505 Brock egistrar's Signatu 31. Date filed (Month, Day, Year) State Registrar MAY 3 1 2905

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8,2006 -N of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner N Joseph Social Security Number more Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day SEPT, 2/ 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days Months Hours 14-38-528 1 M 2 F Director Virginia Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Item 27 le marked other than "natural", or Iteme 23a or 28a-f show other traumatic event, the Madical Exeminar roust by notified at 1 Yes 2 No Director Maryland

10e. Street and Number more 10f. Zip Code 10g, Citizen of What Country? 2207 212 Tre Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea. Depertment of Health and Mental Hygiene. Important: If Item 27 le marked other than "natural" or insparant in the streamatic events. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: 3XWidowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wens Informant's Name/Relationship (Type, Print/grand hter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , 212 Ito. Md 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 ☐Removal from State 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart future. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final uterine tatic metas **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner signature of the state of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) rama Harris this certificate has been signed by the a rail director, page 2 should be detached it 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Onknown 1 ☐ Yes 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan autopsy ormed? 2 No 1□ Yes or Attending Physicien: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 21 No Certification; To 1 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) + 250102 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \ Homicide within 24 hours a To the Funeral D To the Hospital 1 Certifying Physician. To the best of my knowledge, Jeath occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 30, 2006

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed caus of death (Item 23a) (Type, Print)

2006

31. Date filed (Month, Day, Year)

Richey Hospice

32 Registrar's Signature

			1 - For State Registrar	State of Mar		ertificate of I		, ,	iene eg. No 2006	16965
	Physici /Media		Decedent's Name (First, Middle RALPH	, Last) ROSS		HUME		2. Date of Deat Month	th Day Year 27-06	3. Time of Death 5 / 25 9 M
,	Examir		4a. Facility Name (If not institution Franklin Square 1 5 Social Security Number	give street and number)	r	4b. City, Town, or Rosed	Location of Death	h	Raltimo	
١	Funeral Director		063-26-1546		n yrs. last birthday 71 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8-4-1)	Year) 9. Birth	place (State or Foreign ntry) ACHUSETS
	Maryland f ehow	tor	Usual Residence of Oecedent 10a. State 10b. County MD BA	LTIMORE	Oc. City, Town or L	ocation ROSEDAL	Æ			10d. Inside City Limits 1 ☐ Yes 2 No
	death with the Maryland ms 23a or 28a-f ehow	i Directo	10e. Street and Number 1241 NEIGHBO	RS AVENUE		10f. Zip Code	1237	1	0g. Citizen of What Cou	•
_	Jwitin 72 hours atter death with the Marylan jiene. Then "natural", or thems 23a or 28a-f ehow the Madical Examinat must be multiled at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Styres 2 No If Yes, Give Year or Dates: 1		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 🌠 No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: WHT	etc.
<u>.</u>	within 72 hor lene. then "natural to Nedical 1	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or 5+)	(Give	edent's Usual Occupa e kind of work done of DO NOT use retired	ation during most of wor f)	king	16b. Kind of Business/ir	
፭ :	be filed tail Hyg d othe	To Be C	17. Father's Name (First, Middle, I	ast) VRENCE HUMI				ne (First, Middle, M		10.1
Ĕ	s 1 and 2 should f Health and Meni tem 27 is marke other traumatic		NANCY HUME/W	CFE.		NEIGHBOR		ROSLDA		237
E	permit. Pages to Department of Himportant: If ite eny Injury or ot once.		20a. Method of Disposition 1 SuBurial 2 Cremation 4 Donation 5 Other (Sp. 21. Signature at Funeral Service I	3 □Removal from State ecify)	GARDENS	ematory`or other plac OF FAITH	CEM 6-1	-2006 E	20c. Lócation - City or To BALTIMORE DALE FUNES	MD
W. W	Certificate be executed ding physician and main-transit as as the burial-transit	edical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cardiac Due to (or as a c Due to (or as a c Due to (or as a c Due to (or as a c	Arest onsequence of):	1211 CHESA			DALE, MD	21237 Approximate Interval Between Onset and Oeath
0	death e atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ory Day Year
Records, P	iaw requires that the es been signed by th 2 should be detache		Part II. Other significant conditio	ns contributing to death but n I lookol use	ot resulting in the t	underlying cause give	en in Part I.	23e. Did tob	acco use contribute to to	ne cause of death?
ב ו	the stern page	e Compieted by	25. Was case referred to medical					120	prior to condeath?	psy findings available mpletion of cause of 2 No
5	rnysician: rthis certifica ral director,	0 8	examiner?	Hospital:	2 ER/Outpatie	ot 30 DOA Othe		th Check only one		
	rhys rthis and dir	 -	27. Manner of Death	28a. Date of Injury (Month, Day Yo		IN SOLDON	4 Livursing n	ome 5 ⊔ Hesider 28d. Describe ho	nce 6 □Other (Specifi w injury occurred	<i>(</i>)
HOISINIO	spital or Attending Fin ours after death. Peral Director: After th filled in by the funeral	Certification:	1 Atural 5 Pending 2 Accident investig 3 Surcide 6 Could n	ation of be 28e. Place of Injury	- At home, farm, st	M 1 🗆 1	:? ∕es 2 □ No	28f. Location (Str.	eet and Number or Rura	I Route Number,
=	io the hospital of Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a, Certifier 1 Certifying	Physician: To the best of m	v knowledge, deal	th occurred at the tim	e, date and place,	City or Town,	State)	atod
:	vithin 24 h	edical	(Check only 2 Medical E	xaminer: On the basis of ex and manner stated	amination and/or in	nvestigation, in my op	pinion, death occur	rred at the time, da	te and place, and due to	the cause(s)
}		Me	29b. Signature and title of certifier	02120	40	29c. License			d. Date signed (Month,	
	6		30. Name and address of person was Dr. Maykee B.	onyapredee	Gleen 23a) (Type, 9000 /	Print) Franklin S	quare Dr	Ba Himi	5-27-06 ore, Md. 2	1237
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	all p	V		, , , , , , , , , , , ,	

16966 State of Maryland / Department of Health and Mental Hygiene 005 1 - State Certificate of Death

 Physic /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or items 23s or 28a-f show empiripary or other treumatic event. The Medical Examinat must be notified at once.

/Medical

Physician Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Registrar

	- Hegistrar				Dealin		Heg. No.		
an cal	Decedent's Name (First, Middle, Last) LINWOOD EUGENE HARI	Ē				2. Date of De Month May	Day	Yeer 2006	3. Time of Death 4:23 PM
ier	4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, o	r Location of Death	0	4c. Count	ty of Dear	th
	Sinai Hospital	of Bal	timore	Baltim	cre City	+	BALTI	MORE	CITY
	5. Social Security Number 6. Sex		e (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth av, Year)	9. Bir	thplace (State or Foreign ountry)
	212*10*0432	^{2□ F} 84	. Yr:	s.		11-13-	1921		ryĺand
	Usual Residence of Decedent 10a, State 10b, County	-	10c. City, Town o	or Location					10d. Inside City Limits
ō				rford Coun	-vRolain				1 ☐ Yes 2 ☑ No
ect	Maryland Harford 10e. Street and Number		па.	10f. Zip Code	Sy **De Tall		10g. Cîtizen of	Mhat C	
큡		- A			014	ŀ	USA	Wilat Oc	Juliary :
era	506 Lloyd Place Unit	Was Decedent	Ever in II S	13. Was Decedent of H		necify Ves or No		nce - Ame	erican Indian.
Ş	1 Never Married 20 Married	Armed Forces? 1XXYes 2 1 If Yes, Give		If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)		ack, Whit	e, etc.
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WW 11	1 ☐ Yes 2 XX No	Specify:		Spec.	ify: W	hite
Be Completed by Funeral Director	15. Decedent's Educat			ecedent's Usual Occup			16b. Kind of I	Business	/Industry
) ple	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5	11	Give kind of work done ife. DO NOT use retire	d) most of work	King			
Son	8th grade N	/ A	M:	achinist					ve Industry
Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam Zola E		, Maiden Suma	me)	
10	Herbert Hare								
	19a. Informant's Name/Relationship (Type,			Mailing Address (Street					
	Vivian L. Hare (Wife 20a. Method of Disposition	∋)		6 Lloyd Plants of the Control of the		Date Dela	ir, Md.		
	XXBurial 2 ☐ Cremation 3 ☐ Rem	oval from State	cemetery,	crematory or other pla s of Faith	ce)		Baltim	-	
	' 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		Garuen				Dalti	ore,	Mu.
	21. Signature of the property of the circumstance of the circumsta	Anon	~0~	22. Name and Addre Lassanr 7.111	i Funeral lair Rd.	Home Baltim	ore Md	21	236
	23a. Part1. Enter the dis-ase, or complica	tions that	the death. Do not				_		Approximate
	shock, or heart failure. List only one Immediate Cause (Final	cause on each li	ne.					Interval Between Onset and Death	
	disease or condition resulting in death)	Due to (or as	a consequence of	Tinal Trac	nemo	je		1 day	
	Sequentially list conditions b								
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of)	:			-		
аш	Cause (Disease or injury that initiated events resulting in death) Last								
ũ	Tosumy in doain, Last	Due to (or as	a consequence of)	•					
an/Medical Examiner	d		<u></u>						
/Me	IF FEMALE: 23c	If yes, outcome	of pregnancy				224 D	ate of del	h
lan	in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	1				Day Year
Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		o in our (opposity)					
y P	Part II. Other significant conditions contri	outing to death b	ut not resulting in th	ne underlying cause giv	en in Part I.	23e. Did t	obacco use cor	ntribute to	the cause of death?
Completed by	respiratory f	ailun				1 🗆	Yes 2. No	3 🗆 Pr	obably 4 Dunknown
olet	Coronary Cute	ra di	sease			24a. Was	an 24b.	Were au	utopsy findings available completion of cause of
E	nevelval vas	o last	GC : d	ent		autoj perfo	ormed?	death?	
BeC	25. Was case referred to medical	Schland			26. Place of Deal				
To	examiner? 1 Yes 2 No Hos	pital: 1 Inpatie	nt 2 ER/Outpa	atient 3 DOA Oth	er: 4 🗌 Nursing Ho	ome 5 ☐ Resi	dence 6 □Ot	her (Spe	cify)
	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry 28b. Tim y Yea <i>r)</i> Inju	iry Wo		28d. Describe	how injury occu	rred	
cati	2 Accident investigation				Yes 2 □ No				
Certification:	4 Homicide determined	building, et	ury - At nome, tarm c. <i>(Specify)</i>	, street, factory, office		City or To	wn, State)	ber or Hu	ural Route Number,
	29a. Certifier 1 Certifying Physic	ian: To the best	of my knowledge o	leath occurred at the ti	ne, date and place	and due to the	cause(s) and m	anner as	stated
Medical	(Check only 2 Medical Examiner one)	On the basis of and manner sta	examination and/o	or investigation, in my	pinion, death occur	red at the time,	date and place	, and due	to the cause(s)
Me	29b. Signature and title of each los	7	1 4	29c. Licens	e number	29d. Date sign	ed (Monti	h, Day, Year)	
	1 Comments	12	.,MD	1885	- 000		Man 2	5,2	2006
	30. Name and address of person who comp	oleted cause of d	eath (Item 23a) (Ty	/pe, Print)					
	Enter Clarater, M	up din	ni Holpi	tal of Bal	more				
ate rar	31. Date filed (Month, Day, Year) MAY 3 1 2006	32. Registr	ar's Signature	DEALL					

Old Ber Joh

06-03571 Jeffrey Hall

Please Type or Print in Black Indelible Ink Manyland / Department of Health and Mental Hy

пгеу нап		State of Maryland / Department - For State Certification - Cer	te of Death	-	9 No 200	6 1696
Physicia edical Exami		1. Decedent's Name (First, Middle,Last)		2. Date of Death Month May 26, 20	Day Year	Time of Death 1753 hrs
		Jeffrey Louis Hall 4a Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Funeral		402 Arrow Wood Court 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Abingdon lay) If Under 1 Year If Under 24Hrs	8. Date of 8 inth	Harford (MM/DD/YYYY) 9 8inth	place (State or
Director		216-04-2665 1 ★ 2 F 36 Usual Residence of Decedent	Yrs. Months Days Hours Min	— (/1970 Foreign Coul	place (State or Mary Land ntry)
and show any nce,	ō	10a. State Maryland Harford 10b. County Abingd	Location			10d Inside City Limits 1 Yes 2 XNo
ith the Maryland 23a or 28a-f show any notified at once,	Director	10e. Street and Number 402 Arrow Wood Court	10f. Zip Code 21009	10	g Citizen of What Count USA	ry?
r death w or items must be	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	3. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto 1. Yes 2. No specify:		14. Race - Americ White, etc. Specify: Wh	an Indian, 8lack, ite
urs afte tural" antine	d by	15. Decedent's Education (Specify only highest grade completed) 16a. De	ecedent's Usual Occupation (Give kind of		16b. Kind of Business/In	
5-0036 lited within 72 hours after Hygiene I other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ring most of working life. DO NOT use ret ollment Administrat	· ·	Insurance	
21215-0 uld be filed w Marked other e event, the M	Be	17. Father's Name (First, Middle, Last) Louis Stanley Hall	Joy Ma		holtz	
MD 2	То		Mailing Address (Street and Number or 12 Arrow Wood Court			
Baltimore, MD 21215 perair Pages I and 2 should be file Departir Pages I and 2 should H Important: If item 27 is marked of injury or other traumatic event, the		20a. Method of Disposition 1 Surial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	Disposition (Name of cemetery, y or other place) op Service Inc. 6-	Date -1-06	20c. Location - City or T Towson, Max	
Balti permit Departn Imports injury o		31. Signature of Funeral Service Licensee	22. Name and Address of Facility MC(P.A. nd 21009
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not failure tist only one cause on each line.		r respiratory arres	st, shock, or heart	Approximate Interval 8etween Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a Saddle Pulmonary Thromboe Due to (or as a consequence of):	mbolism			Deali
	-E	Sequentially list conditions, if any, leading to immediate b Lower Extremity Deep Venous Due to (or as a consequence of):	s Thrombosis			
_	Examiner	cause Enter Underlying Cause (Disease or injury that initiated c.				
executed an and al - transit	EX	events resulting in death) Last Due to (or as a consequence or): d.				
8 E = 1	Medical	UNPENDED AMENDED				
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death rote friends Director: After this certificate has been signed by the attending physical completely filled in by the funeral director, page 2 should be detached for use as the burit	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pregna Other (Specify)	ancy	23d. Date of delivery Month Da	ay Year
O. Bo tr the deat by the at ached for	Phys	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting	n the underlying cause given in Part I	23e. Did tob	pacco use contribute to the	ne cause of death?
, P.O ires that t signed b	ð			· -	2 No 3 Proba	
cords, law requir has been s	Completed			24a, Was au autops perform	y prior to co	opsy findings available mpletion of cause of
tal Rectant The certificate		25. Was case referred to medical	26 Place of Death (Check	1 ✓ Yes 2	No 1 ✓ Yes	2 No
Vital lysiclan: this certif	o Be	examiner?	Other		Residence 6 🗸 Other	Scene
Division of Vital Records, rat or Attending Physician: The law require and an alloredore. After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2.	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	me of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:		n, street, factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Rura ate)	al Route Number, City
To the Hoss within 24 hc To the Fun completely	Medical (29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invand manner stated				
	Me	29b. Signature and title of certifier	29c License number O.C.M.E.		29d Date signed (Mont May 27, 2006	h, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)				
10		Too De lista de Circata	ner 111 Penn Street, Baltimo	re, MD 21201		
S Regis	tate trar		Greeke .			
DHMH 17 Rev 1/2	2001	ORI	SINAL			

DHMH 17 Rev 1/2001 OCME 2006

		•	1 - State of Maryland / Dep	eartment of Health and Mertificate of Death		giene Reg. Nó. 0	16968
	Dhusisi		1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	ath Day	3. Time of Death
	Physicia /Medic		Jean Marguerite Henning		May 26		9:55 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County	of Death
			2445 Dixie Lane	Forest Hill If Under 1 Year If Under 24 Hrs.		Harfor	
	Funeral		5. Social Security Number 6. Sex 1 M 2 TF 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birt (Month, Day	y, Year)	Birthplace (State or Foreign Country)
	Director		215-16-0709 83 Usual Residence of Decedent		Feb. 6	, 1923	Maryland
	ylano now		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	a-f sl	tor	Maryland Harford Forest H	ill			1 ☐ Yes 2 XNo
	or 28	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of V	Vhat Country?
	23a	a	2445 Dixie Lane	21050		USA	
	r dea	ne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sport Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rac Blac	e - American Indian, ck, White, etc.
36	s afte	by Funeral	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No ☐ If Yes. Give	1 ☐ Yes 2√ No Specify:		Specify	<i>I</i> :
8	72 hours after death with the Maryland Inaturat', or items 23a or 28a-f show disal Examinat must be notified at			edent's Usual Occupation		16b Kind of Bu	White Usiness/Industry
21215-0036	n na	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of worki DO NOT use retired)	ing	TOD. TRING OF DO	ioniosamaasty
212	yiene giene r tha	FO	Elementary/Secondary (0-12) College (1-4or 5+)	maker		Own Ho	ome.
פ	e filed of the vent,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle,		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturat," or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	To	Charles Christian Rehberger, Jr.	Lorrain	e Margu	erite Ra	aither
lan)	2 sho and I is ma			ling Address (Street and Number or Rura			
2,	and ealth m 27 her tr		Melvin Frederick Henning/Husband 244				
Baltimore,	ges 1 t of H If Ite or ot		REBurial 2 Cremation 3 Hemoval from State	ematory or other place)	Date		City or Town, State
ij	t. Pa tmen tant: njury		'4 □Donation 5 □ Other (Specify) Trinity	Lutheran Cem. 5-31			Maryland
Bal	permi Depa Impo any ir			2 Name and Address of Facility McComas Funeral Hor			
			23a Rad 1 Enartha disease or complications that caused the death. Do not or	1317 Cokesbury Road	d, Abing	gdon, Ma	aryland 21009
	AND DESCRIPTIONS		23a. Part1. Exten the disease, or complications that caused the death. Do not en shock, or healt failure. List only one cause on each line. Immediate Cause (Final			, ,	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) a	TIVE heart jui	reco		
	Examiner		Due to (or as a consequence on):	tive heart tail the Stenosis	?		
		Jer					
	cuted id ransit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
oʻ	an ar urial-tı	Ex	resulting in death) Last Due to (or as a consequence of):				
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dicai	d				
9	entific ding p	Med	IF FEMALE: 230 If you guiteome of progressive				
Вох	eath certif attending for use a	ian/	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Dat Mor	e of delivery nth Day Year
o.	he de	Physician/Med	1 Yes 2 TNo 4 Fregnant at time of death 5 9 Unknown	☐ Other (specify)			
٣	requires that the de een signed by the a nould be detached f	Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contr	ribute to the cause of death?
Vital Records	pulres n sign	d by	Diabetes Meilitus	_	1 □ Y	es 2 2 No	3 ☐ Probably 4 ☐Unknown
000	> 0 0	Completed	Itigh blood press	Sure_	24a. Was a	an 24b. V	Vere autopsy findings available
Re	9 7 9	omp	, <u> </u>		autop: perfor	med?	prior to completion of cause of leath? Yes 2 No
ta	siclan: Th certificate rector, pag	0	25. Was case referred to medical	26. Place of Death			
/	8 0 D	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing Ho	ne 5 🔀 Resid	ence 6 Othe	ar (Specify)
n of	ding Phi h. After thi funeral		27. Manner of Death 1 Natural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 1 Injury	of 28c. Injury at Work?	28d. Describe h	ow injury occurre	ed
sio	Attending r death. ector: After by the fune	catio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	I or Attencatter death Director:	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (S City or Tow		er or Rural Route Number,
	Hospital or Atten 24 hours after deatl Funeral Director: stely filled in by the	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th conversed at the time, data and along	and due to the a		
	4 Tu P 9	edical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	nvestigation, in my opinion, death occurr	ed at the time, o	late and place, a	and due to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature/and title of certifier	29c. License number	2	29d. Date signed	(Month, Day, Year)
	PSF0) Solutt one mo	D00235	19	may :	30, 2006
	1		30. Name and address of person who completed cause of death (Item 23a) (Type Robert Court unit unit 230)	Print) A	0	10-1	M. N = 141
l	0		Kobert LSmith up - 230\$	Idelaiv Rd	ta	elston	1, MI) 21047
	Sta		31. Date filed (Month, Day, Year) MAY 3 1 2005	At 1			
	Registr	ar	MAY 3 1 2006 Merces St. April				

		•	For State Registrar	State of Ma	ryland / Depa	artment of H			giene	006	16969
ı	Physici	an	1. Decedent's Name (First, Middle,	Last) LLOYD DANI	ет. натет	FT.D		2. Date of De	ath Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution,		DD HAIFT.	4b. City, Town, or	Location of D			2006 County of Death	3:00 A M
	Lxuiiiii	C1	4327 OLD HAN	OVER RD.		WESTMI	INSTER	3	C.	ARROLL	
	Funeral Director		5. Social Security Number 214-34-3686 Usual Residence of Decedent	6. Sex 7. Age	(In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir (Month, Da 1 / 5 / 1	th ly, Year) 935	Cou	place (State or Foreign ntry) NESSEE
	yland		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	e Mar	ctor	MD CARRO	LL	WESTMIN	STER					1 ☐ Yes 27 No
	death with the Marylan eme 23a or 28a-f ehow r cutat be collified at	Director	10e. Street and Number 4327 OLD HANG	מעשם פו		10f. Zip Code 21158	.		-	en of What Cou SA	ntry?
	heath me 23	Funerai	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.			? (Specify Yes or No Puerto Rican, etc.)		4. Race - Ameri	can Indian,
215-0036	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23a or 28a-f ehow the Medical Examinar must be motified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:	0	if Yes, specify Cuba 1□ Yes 2∑ No	n, Mexican, P	Puerto Rican, etc.)		Black, White, Specify: WH	, etc. HITE
<u>ဂ</u>	72 hc	etec	15. Decedent (Specify only highest		(Give	dent's Usual Occupa kind of work done o	during most of	f working	16b. Kin	nd of Business/Ir	ndustry
1212	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	DO NOT use retired TRUCK D			TRA	NSPORT	NOTTAT
	be filed tai Hygi d other event, I	Be Co	17. Father's Name (First, Middle, L	ast)				Name (First, Middle			
Maryland		ToE		NOAH	HATFIEL			SARAH M			
Mar	s 1 and 2 should F Health and Mer Item 27 ie marke other traumatic		19a. Informant's Name/Relationsh KAREN G. WACK		1			or Rural Route Numb NOVER , PA			o Code)
	F Healf		20a. Method of Disposition	ER -DAUGHI	20b. Place of Dispo	sition (Name of		Date PA		7331 cation - City or T	own, State
Ē	m 0		1. Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from State ecity) M	EADOW BR	natory`or other plac .ANCH CEI	1 .	1/06	WES	TMINST	ER, MD
Baltimore,	permit. Page Department Important: If eny injury or once.		21 Signatura d'Auner I Service L	icensee	22	2. Name and Addres	s of Facility	FLETCHER			
1)	20 E 2 9							WESTN		TER, MI	
	Physician /Medical		23a. Part1. Emerthe disease, or o shock, or hear failure. List of Immediate Cause (Final disease or condition resulting in death)	omplications that caused to his one cause on each line a. Metaste	э.	on Cana		rdiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner		,	Due to (or as a	consequence of):						
	TA -	ner	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that intend events.)	b. Oue to (or as a	consequence of):						
	and transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	с.							····
, 0 0	Ite be executed tysicien and ne burial-transit	ical E		Due to (or as a	consequence of):						
280	ificate g phys as the	edic		d							
Š	death certificate e attending phys d for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		Ectopic pregnancy			23	3d. Date of deliv	•
j D		ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at ti 9☐ Unknown	ime of death 5	Other (specify)				Month	Day Year
7	law requires thet the as been signed by th 2 should be detache		Part II. Other significant condition	s contributing to death but	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco us	se contribute to t	he cause of death?
cords,	w requires been sign should be	ed by						10	Yes 2.₩	No 3□Pro	pably 4 □Unknown
Zeco Zeco	The law re cete has be page 2 sho	Completed						24a. Was		24b. Were auto prior to co death?	opsy findings available impletion of cause of
VItal	icien: The certificete ha ector, page	a	25. Was case referred to medical	31			26 Place of	1 ☐ Yes Death (Check only of	2 1 No	1 ☐ Yes	2 No
5	Physicien: r this certifice ral director, p	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatien	t 3 DOA Othe		ng Home 5 Resi		Other (Special	(y)
	gr en		27. Manner of Death 1 SNatural 5 ☐ Pending		Year) 28b. Time of Injury	28c, Injury Work	at c?	28d. Describe			
DIVISION	Attending ir death. ector; Afte by the fune	ficat	2 Accident investig: 3 Suicide 6 Could n	ot be 28e. Place of Injur	ry - At home, farm, str		Yes 2 □ No		Street and	Number or Run	al Route Number,
Š	s after of Dire	Certification:	4 Homicide	building, etc.	(Specity)			City or To	vn, State)		
	To the Hospital or Attendit within 24 hours after death. To the Funerel Director; A completely filled in by the fu	Medicai (29a. Certifier 1 Certifying (Check only one)	Physicien: To the best of ixaminer: On the basis of e and manner state	examination and/or in	n occurred at the tim vestigation, in my op	ne, date and pointion, death o	place, and due to the occurred at the time,	cause(s) a date and p	and manner as s place, and due t	stated. o the cause(s)
	To ti To ti comp	Ž	29b. Signature and title of certifier			29c. License				signed (Month,	
	.\			They ca			6220	9	May	30, 20	006
	8		Dr. Thomas C.	Keller 250	ath (Item 23a) (Type,		ر کی	Homono,	Pc.	1775)	
1	Sta Registr	ite ar	31. Date filed (Month, Day, Year) MAY 3	2006 32. agistrar	r's Signature	met)					

DHMH 17 Rev 1/2001

ORIGINAL

		1- For State Registrar	Stat	e de la lyle		rtificate c	of Health and of Death	nd Menta	ygie	Reg	No. 2	00	6 I	697
Physici	an/	1. Decedent's Name (F		,					Mo	ite of Death	Day Ye		3. Time of D	
lical Exam	ner	Lawre 4a. Facility Name (if no	nce J	loseph l	<u>Hoyt, J</u>	r.	4b. City, Town, o	or Location of	Ma	y 21, 200	6 4c. County	of Death	1603 hi	s
		3600 East Mor			mber,		Baltimore	or Education of	Dodin		To. County	or Beatin		
Funeral		5. Social Security Number		Sex	7. Age (In yrs. I	last birthday)	If Under 1 Ye		1.0		(MM/DD/YYY	Y) 9. Birth Foreign		or
Director		212.72.8		≤ M 2 F	48	Yr		ays Hours	Min. (06-20	- 57	Cou	intry)MD	
any		Usual Residence of De 10a State 10b	cedent c. County		10c. City	, Town or Loca	ition						10d Inside (City Limits
# .	_	MD	Harfo	rd	Ab	ingdor	ח						1 Yes	2. No
72 hours after death with the Maryland n "ustural", or items 23a or 28a-f show al Examiner must be notified at once,	Director	10e, Street and Number	er .				10f. Zip Code			10g	. Citizen of W	/hat Count	try?	
th the 23a or notifie	Ö	4034 Tim	othy					1009			U.S			
ath wi items ist be	Funeral	11. Marital Status1 Never Married	2 Marri	A	edent Ever in U		as Decedent of H Yes, specify Cub					e - Americ te, etc.	an Indian, B	ack,
ifter de il", or ner mi	by Fu	3 Widowed	4 Divorc	If Yes, Give Yea	r Z No	1	Yes 2 N	lo specify:			Specify:			
nours a		15. Decedent's Educa					nt's Usual Occup			one 1	6b. Kind of B	usiness/In	dustry	
36 mm 72 m. hau " dical I	Completed	Elementary/Seconda	ary (0-12)	College (1	-4 or 5+)	Labo	orer				Carpe	nter	•	
215-0036 be filed within 5 ntal Hygiene. sked other than ent, the <u>Medica</u>	Con	17. Father's Name (Firs	st, Middle, La	i <u>1</u>				18.Mother's	Name (First,		iden Surnam			
2121 uld be fil Mental F marked c event,	Be			seph H	oyt, S						Dean He			
Baltimore, MD 21215-0036 remit Pages 1 and 2 should be filed within 72 hours after de Opeanment of Health and Menal Hygiene. Inportant: If item 27 is marked other than "natural", or njury or other traumatic event, the Medical Examiner, m	To	19a. Informant's Name/ Ashlev H			r		ng Address (Str Arncli						Zip Code) 212	21
e, N 1 and 2 Health item 2		20a. Method of Disposi	ition		0.01	D: (D:	TP (61		5 .			- A		
Saltimore, permit Pages I an Department of Her mportant: If ite		1 Burial 2 4 Donation 5	Other Spec	eifv:	om State Ch	esapea	ostrion (Name of continuous place) ak Crem	atory	05.30	0.06	Belts	vill	le, M	D
Balti permit Departm Importa injury o		21 Signature of Funera	al Service Lic	censee	1	22.	Name and Addre	ss of Facility	Crem	natio	– n And	Fur	neral	
		du da X	L. ak.	11 4	1111111		_							0.4
Dhycidian		23a. Part I. Enter the d	isease, or co	mplications that c	aused the death	Do not enter	Alterna the mode of dvin	tives	8717	7 Gre	en Pa	stur eart	es D.	te Interval
Physician Medi⊂al		failure. List only o	one cause on	each line.			Alterna the mode of dyin	tives g, such as car	8717 diac or respi	7 Gre iratory arres	en Pa t, shock, or he	<u>stur</u> eart	Approxima Between C	Inset and
a little and a second		23a. Part I. Enter the difailure. List only different condition resulting in	one cause on al disease	each line. a. <mark>Heroin a</mark>		lol intox		tives g, such as car	8717 diac or respi	7 Gre iratory arres	en Pa	<u>stur</u> eart	Between C	nset and
Medi⊏al	ər	failure. List only of Immediate Cause (Fina or condition resulting in Sequentially list condit	one cause on al disease n death) tions,	a. Heroin a Due to (or as a	nd tramad consequence o	lol intox		tives g, such as car	8717 diac or respi	7 Gre iratory arres	en Pa	<u>stur</u> eart	Between C	Inset and
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			For State Registrar	State of Ma		epartment of F		ental Hygie	C 0 0)6	16971
	Physici	an	1. Decedent's Name (First, Middle, La		. 1	VOUN-COA		2. Date of Death Month		Year	3. Time of Death 2230 M
	/Medic Examin		4a. Facility Neme (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
	Funeral		Anne Arundel M 5. Social Security Number 6. S		Inter (In yrs. last birth		ff Under 24 Hrs.	B. Date of Birth	Anne	9. Birthp	lace (State or Foreign
Sir.	Director		212-54-7531 ¹ Usual Residence of Decedent	□M 2DF	57 Y	rs. Months Days	Hours Min.	Jan 13	1949	Mary	
	aryland show	,	10a. State 10b. County Maryland Anne A		10c. City, Town					1	Od. Inside City Limits
	the Market	Funeral Director	10e. Street and Number	runder	Annap	10f. Zip Code		10g	Citizen of W	/hat Coun	try?
	ath with	rai Di	29 W. Washingt	_		2140			USA		
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dep _{er} tment of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Iteme 23e or 28a-f ehow any injury or other traumatic event, If a Medical Exaction final Legicular confided at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 Yes 20 No	ispanic Origin? (Spec in, Mexican, Puerto R Specify:	fy Yes or No- can, etc.)	Black	- Americ k, White, Bla	
2-0-7	hin 72 ho s. in "natur Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+		Decedent's Usual Occup. 'Give kind of work done o life. DO NDT use retired	during most of working	161	o. Kind of Bu	siness/Inc	lustry
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Mar	nd 2 shoulth and 27 is ma		19a. Informant's Name/Relationship (Kendall Fryor(Mailing Address (Street and Dominoe R					Code)
oanumore,	Pages 1 and neut of Healent: If Item ury or other		20a. Method of Disposition 1 Burial 2 Coremation 3 4 Donation 5 Other (Specif		20b. Place of cometery Me C1 C	Disposition (Name of , crematory or other place C1 emator	Da y 5-30-		alti.m		
02	pemit. Departi		21. Signature of Funeral Service Licer	nsee Mcc48	3	Win Name Red Section 821 West	^{gof&acil} gons St. Anna	Mortua: polis,	cy, P Md. 2	.A. 1401	į.
Ī			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused t	he death. Do no	ot enter the mode of dyin	g, such as cardiac or	respiratory arrest,			Approximate Interval Between Onset and Death
	Physician /Medical	V (1)	fmmediate Cause (Finaf disease or condition resulting in death)	a	consequence o						50
	Examiner	1	Sequentially list conditions,	b. A NOX	consequence of	BRAIN SHU) AMAGIE				10 D
	cuted nd na ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		ORRAG	E SHUC	-16				10h
0/00,	cate be executed physicien end	dicai Ex	resulting in death) Last	Due to (or as a	consequence of						
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ecords, r.	equires that en signed by ould be deta	þ	Part fl. Other significant conditions of	LUNG	C.	the underlying cause give	en in Part I.	23e. Did tobac		bute to th	e cause of death? ably 4 Unknown
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Vila	ysicler is certif director	To Be	25. Was case referred to medicat examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 Anpatien	t 2 ER/Out	patient 3 DOA Other	26. Pface of Death (er: 4 ☐ Nursing Home		e 6 □Othe	r (Specify)
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	3		30. Name and address of person who	completed cause of dead	ath (Item 23a) (1	ypa Print) DEFEUSE	14 G 4016	y Ann	apous	Mr	121401
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			For State Registrar	State o	f Mary	land / Dep <i>Ce</i>	artmen rtificat			and M	lental Hy	gien Reg. N	2006	the color was	69	72
			1. Decedent's Name (First, Middle	e, Last)							2. Date of De	ath	ayYear		rime of I	Death
	Physicia /Medic		Raymond	E. Harri	s, Jr	•					May	30	2006	12	:50	ам
	Examin		4a. Facility Name (If not institution Gilchrist	n, give street and nu	mber)				Location o	of Death		4	c. County of De			
			5. Social Security Number	6. Sex	7 Age (in	yrs. last birthday		WSON	If Under	24 Hrs.	9 Date of Ri	rth	Baltim	ore inthplace (Ch to o	r Foreign
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	arylar show	_	10a. State 10b. County			. City, Town or L	ocation								side City	y Limits 2 √ No
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			30. Name and address of person	who completed cau	se of death	(Item 23a) (Type	. Print)	dani	N.	140	2155 6	1411	Ay 30	~06		
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	1 - For State Registrar Amond		nd / Department of Health and Certificate of Death C856 6/07/06 JH	2.0	"2000 IC072
Physician /Medical	1. Decedent's Name (First, Midd	FZ&S PET PHY &FH	G836 6/0//06 JH	2. Date of Death Month 2	Thay Year 3. Time of Death 2:30 PM
Examiner Funeral Director	4a. Facility Name (If not institution STELLA MARIS 5. Social Security Number 213-70-2388 Usual Residence of Decedent		4b. City, Town, or Location of De TOWSON [ast birthday] Yrs. 4b. City, Town, or Location of De TOWSON [f Under 1 Year If Under 24 H Months Days Hours Mi	S. B. Date of Birth (Month, Day, Ye	4c. County of Death BALTIMORE
faryland	10a. State 10b. County		ty, Town or Location		10d. Inside City Limits 1 X Yes 2 ☐ No
death with the Maryland me 23e or 28e-1 show trivial be notified at neveral Director	MD 10e. Street and Number		LTIMORE 10f. Zip Code	10g.	Citizen of What Country?
036 urs after death v el', or iteme 234 Examinar manat by Funeral	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Uyes 2 No	21217 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: BLACK
l 21215-00 ed within 72 hou ygiene. Then "nature it, tre Medical Et, tre Medical Completed	15. Deceder (Specify only highe	nt's Education st grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking 16t	b. Kind of Business/Industry
Maryland 21215-0036 2 should be tited within 72 hours atter the and Mental Hygiene. 27 is marked other then "naturel", or Its reaumatic event, the Medical Examina To Be Completed by Fu	Elementary/Secondary (0-12) 1 2 TH 17. Father's Name (First, Middle,	College (1-4or 5+) Last)	SELF-EMPLOYED	ame (First, Middle, Mai	AUTO MECHANIC
ylan could be i Mental i Menta	WINFIELD JOH		SYLVIA	BARNES	- ,
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if them 27 is marked other then "naturel", or iteme 23e or 28e-1 show any Injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relations IRVIN JOHNS 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 □Removal from State Specify) 20b. F	19b. Mailing Address (Street and Number of Mailing Address (Street and Number of Mailing Address of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition)) [LANEY VALLEY 05/] 22. Name and Address of Facility WE	BALTIMO 200	
tificate be executed in the principle of the prinal-transit as the burial-transit as the burial-transit fedical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Einer Universitying Cause (Disease or injury that initiated events resulting in death) Last	aCOLON_CANCE Due to (or as a conseq b Due to (or as a conseq c Due to (or as a conseq d	uence of):		Onset and Death
the death certification of the attending ached for use a hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of de 9 □ Unknown	I death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
Cords, P w requires tha been signed I should be det	Part II. Other significant condition	ons contributing to death but not resu	ulting in the underlying cause given in Part I.		co use contribute to the cause of death? 2 □ No 3 □ Probably 4 ▼ Unknown
Vital Records, sician: The law requires th certificate hes been signe rector, page 2 should be of Be Completed by				24a. Was an autopsy performed 1 ☐ Yes 2X	
of Vita Physician: this certific ral director,	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	10.1	eath (Check only one) Home 5 Residence	6 X Other (Specify) HOSPICE
Jing After funer	27. Manner of Death 1 X Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could 4 Pendide determ	gation not be ined 28e. Place of Injury - At ho	28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	
	29a. Certifier TCertifyin	building, etc. (Specify	wledge death occurred at the time, date and place	City or Town, St	ale)
To the Hoep within 24 hou. To the Fune completely til	one) 2 Medical	and manner stated.	tion and/or investigation, in my opinion, death occ	urred at the time, date a	and place, and due to the cause(s)
T wild oo	29b. Signature and tiple of certifie	10-	29c. License number DUS72	29d. [Date signed (Month, Day, Year) 5/22/06
	30. Name and address of person DR. TARIO MAHN	who completed cause of death (Item		, MD 21093	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signar		, LIUJJ	

			For	State of Marylan	· ·		Mental Hygier	1e	
			1 - State Registrar		Certifica	te of Death	Reg. N	10.2006	16971
	Physici	an	Decedent's Name (First, Middle, Last)	1	JONE	<		Day Year	3. Time of Death
1	/Medi		ROBERT 4a. Facility Name (If not institution, give:	street and number)		y, Town, or Location of Dea	MAY 2	4c. County of Death	8 - 4 / M
7	Examir	ner	BON SECOUR	S HOSPIT		BAITI	MARE	N. County of Boats	A
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		er 1 Year If Under 24 Hr		9. Birthpl	ace (State or Foreign
	Director		412-30-6343	M 2□ F 7.	3 Yrs. Months	S Days Hours Mir	APRIL 14,1	933 197	FRYLAND
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location			10	Od. Inside City Limits
	Maryl f aho	ō	MARINAUN N/A			BAITIM	ORE CIT		1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number		10f. Z	ip Code		Citizen of What Count	try?
	th with	a D	1315, AUG	USTA AVE	NUE	212	29	U.SA.	
	ams arm	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Dec	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - America Black, White, e	
36	or it	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 (2NYes 2 □ No If Yes, Give	1 ☐ Yes		. ,	Specify: R	1011
5-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f ahow disal Examinar must be notified at	ed p	15. Decedent's Edu	Year or Dates:	16a. Decedent's Us	ual Occupation	16h	Kind of Business/Indi	HCK
215	within 72 ene. then "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind of w	ork done during most of w use retired)	orking	Killo of Dasillos Sillo	ustry
21	giene giene	E O	12 HGRADE	Oollege (1 40/ 54)	LONG	SHORE M	AN 5	TEAMSHIP	TRADE ASSIN
and	ild be filed lental Hygii ked other ilc event, I	Be	17. Father's Name (First, Middle, Last)	_	13.6.4	18. Mother's Na	ame (First, Middle, Maide	on Sumame)	1
	i Men Marke natic	10	WILLIAM		IONES	V/0	LA.	GUEEN	V
Mary	s 1 and 2 should be filed within 72 hours after death with the Marylan if Heelth and Mantal Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified as	ł	19a. Informant's Name/Relationship (Ty MICHELE JONES	pe, Print)	19b. Mailing Addres	ss (Street and Number or F			/
	1 and Heelth tem 27 other tr		20a. Method of Disposition	20b. F	Place of Disposition (N	AUGUST		Location - City or Tow	0. 21229 vn. State
ē	@ · = 6		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	emetery, crematory or		-01-06 K	BALTIMAN	
Baltimore	permit. Pag Department Importent; any Injury once.	1	21. Signature of Funeral Service Licens	96 // \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	, 22. Name		ROWNJR	FINERA	HOME
ä	90 E 8 9		Wetrich	N.Wille	an 294	ON. FULTO		92TO, MO	_
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deat	h. Do not enter the mo	ode of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CHRON	ic OBST	PHETIVE 2	LUNG DIE		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):		,		10 2111
	Examine	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq		TIL HEAR	T DISEAS	Eu	NENOWN
	夏 夕秦	nlne	Cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	derice (ii).				
Ć,	sicien and burial-transk	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
092	ate be ex nysicien he burial	ical		I					
68	ntifica ng ph as th		IF FEMALE.						
Вох	death certifica attending pt for use as th	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		pregnancy		23d. Date of delivery	,
0.	at the dea by the al	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of di 9☐ Unknown	eath 5 Other (s	pecify)		Month D	Day Year
P.0	that the ed by detec		Part II. Dther significant conditions con	tributing to death but not res	ulting in the underlying	cause given in Part I	23e. Did tobacco	use contribute to the	cause of death?
of Vital Records,	uires tha signed I	d by	HYPERTI	Α.		given in tale		2 □ No 3 □ Probal	
S	w require been sign	ete		TOS EXPO	SIPE		24a. Was an		sy findings available
Re	he lav e has age 2	Completed	7, 7, 7, 2	/			autopsy performed?	prior to comp death?	pletion of cause of
ita	sician: The certificate h rector, page	0	25. Was case referred to medical			26. Place of De	1 Yes 2 N	lo 1 Yes 2	!∐ No
*	nysic nis ce direc	To B	examiner? 1 Yes 2 No		ER/Outpatient 3 D	104	Home 5 Residence	6 Other (Specify)	u.
0 0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how inju		
sio	ttandi death. ctor: A / the fu	cati	2 Accident investigation 3 Suicide 6 Could not be		М	1 ☐ Yes 2 ☐ No			
Division	or At after of Dirac in by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, facto v)	ry, office	28f. Location (Street a City or Town, State	ind Number or Rural I te)	Route Number,
_	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transk		29a. Certifier 1 Certifying Phys	sician: To the best of my kno	wledge, death occurred	d at the time, date and place	a and due to the cause/	e) and manner as sta	tod
	n 24 h	Medical	one) 2 Medical Examin	ier: On the basis of examina and manner stated.	tion and/or investigatio	n, in my opinion, death occ	urred at the time, date ar	nd place, and due to the	he cause(s)
	To the To the To the Comp	ž	29b. Signature and title of certifier	2 1000	29	c. License number	29d. D	ate signed (Month, Di	ay, Year)
			<i>\mathcal{J}</i>	NO COLORS	D.	D 23300		MAY 2	5- 2006
	n		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print)	BON SERO	URS 7205	P	
			SUDKIR 1	D. PATEL	2000W	BALTO.	31 BA2	TO MAD	2/223
	Sta Registr	ite ar	29b. Signature and title of certifier 30. Name and address of person who co SUDICIR 31. Date filed (Month, Day, Year)	6 History Signa	& Sparker				

06-03537		Please Type or Print in Black Indelible Ink			
Deborah Patricia	Joh	nspn State of Maryland / Department of Health and Mental H	ygiene		
		- For State Certificate of Death	Red	1. No. 200	6 1697
Dhuaisia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
Physicia Medical Examir	111/		Month	Dav Year	0455 hrs
Medical Examin			May 25, 20		
*		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
		Bon Secours Hospital Baltimore		N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	. 8. Date of Birth		hplace (Stata or
Director		216-78-6690 1 M 2XIF 46 Yrs. Months Days Hours Min	July 1	3, 1959 Foreig	untry) Maryland
J.: 0010.	L	216-18-6670 1 M 2XF 46 Yrs.	July 1	3,7131 00	anay) Meet of Lealer
		Usual Residence of Decedent	·		
япу	1	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
p of	_	Maryland N/A Baltimore			1 X Yes 2 No
th the Maryland 13a or 28a-f show notified at once.	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	ntrv?
Mai r 28	ě	230 North Carey Street, Apartment 1 21223		United S.	
a o ifi	ا 🖻	230 North Carey Street, Apartment 1 21225		venited 9	1,0,00
with with	Funeral	11. Marital Status 12. Was Decedant Ever in U.S. 13. Was Decedent of Hispanic Origin? (Status			can Indian, Black,
item item	힅	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
ab a m		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: B	ack
s aft	ā	or Dates:	work done	16b. Kind of Business/I	
nour ratu		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of volume for the during most of working life. DO NOT use retired.			
72 12 1	e	Elementary/Secondary (0-12) College (1-4 or 5+)		Rosewood	Center
edic than	위	12 Supervisor		,	
5-0036 Iled within 7 Hygiene. d other than	Completed	17. Father's Name (First, Middle, Last) 18.Mother's Name		aiden Surname)	
215 be file ontal Hy rked o	Be	Richard Epps Verti	e Epps		
21215-0036 Juld be filed within 72 hours afte Mental Hygiene, marked other than "natural"; ic event, the Medical Examiner.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I		nor City or Town State	Zin Codo)
hould by a stice at tice at the stice at the	유	Demetrica Johnson-Daughter 230 North Carey St.,	Ant	Bultinue	MD 21113
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after near of Health and Mental Hygiene. mart: If tiens 27 is marked other than "natural"; or other traumatic event, the Medical Examiner.			NP		
Hear Hear		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	
ges trof		1 Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: Mount Carmel Cemetery 2	2006	Baltimore	, Maryland
Pa Pa men tant	ļ	4 Donation 5 Other Specify: Mount Carmer estreets			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	ı	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Calvin L. Williams	Funeral	Service, P.	A
E. E. D. & CD		1 9 min 2. 1651	Baltimor	e, mary la	nd 21229
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	or respiratory arre	st, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line.			Between Onset and Death
aminer.		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Heart Diease Due to (or as a consequence of):			
7		or condition resulting in death) Due to (or as a consequence of):			
	_	Sequentially list conditions,			
	ne ne	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
	Examiner	(Disease or injury that initiated			
₹ g \	×	events resulting in death) Last Due to (or as a consequence of):			
executed ian and ial - transit	ical	d			
e ex	di.	UNPENDED AMENDED			
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be refeast. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the buri	sician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	y
87 iffica in the pass the	2	23b. Was decedent pregnant in the 1 Live high 5 Fetal death 3 Ectopic pregnant	ancy	Month	Day Year
cert cert	cia.	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
Box e death of the attented for us	ysi	1 Yes 2 No 9 V Unknown g Unknown		1	
the of	Phy	Part II. D ther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	pacco use contribute to	the cause of death?
P.O s that t gned b	by		1 Ves	2 No 3 Pro	nably 4 V I Inknown
ires ires 1 be					
ords, w requir	ompleted		24a. Was a		topsy findings available completion of cause of
law has	d.		autops perfor		completion of cause of
Zec The The licate	ō		1 Yes 2	No 1 Y	es 2 No
rriff.	Ö	25. Was case referred to medical 26.Place of Death (Check	only one)		
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by weral director, page 2 should be detach.	0	examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Dther; 4 Nursi	ng Home 5 I	Residence 6 Othe	r:
Phy er th	ို	Tes 2 No	28d. Describe h	ow injury occurred	
fing Pl	Certification:	(Month, Day, Yaar)		,,	
tor:	ä	Natural 5 Pending 1 Yes 2 No 2 Accident Investigation			
r At ter d irec irec in by	Ę	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.			ıral Route Number, City
Division tal or Attendi is after death.	Ë	determined (Specify)	or Town, St	ate)	
Div lospital or I hours afte uneral Div	ŭ	- Homide	d due to the co	(a) and marries :	
n 24 ie Fu	cal	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred	at the time date :	and place, and due to the	ieu. ie cause(s)
Division To the Hospital or Attendin within 24 hours after death. To the Foueral Director: A completely filled in by the fu	ledical	and manner stated.	and anno, date o		
F = F 5	ž	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
		O.C.M.E.		May 25, 2006	
A		Jun Mon - Other			
Λ.		30. Name and address of person who completed causa of death (Item 23a)	- MD 04004		
7		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimo	re, MD 21201		
S	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature			
Regis	trar	MAY 3 1 2006 Regions De Mayor			
		1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1 - For State Registrar		partment of Health and I e <i>rtificate of Death</i>	Mental Hygiene	6 16976
Physician /Medical	1. Decedent's Name (First, Middle, Last	ford Jones		2. Date of Death	3. Time of Death
Examiner	A = 100 At - 45 At - 45 At - 1	street and number)	4b. City, Town, or Location of Death Ba Wimore		ya
Funeral Director	Social Security Number 6. Se			8. Date of Birth (Month, Day, Year) May 3, 1911	Birthplace (State or Foreign Country)
Pu »	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location	744 3) 14 11	10d. Inside City Limits
in the Marylan or 28s-1 show who willed at	Md N/A	Baltin			1 Yes 2 □ No
of state of the marked of the	10e. Street and Number 808 N. Monro	e Street	10f. Zip Code	10g. Citizen of Wha	,
036 ours after des ral', or iteme Examilier out	3 Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerting Yes 1 Yes 2 No Specify:	pecify Yes or No- b Rican, etc.) 14. Race - Btack, V	American Indian, White, etc. Black
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygene. Important: If item 21 a marked of other then "natural", or iteme 23s or 28s -1 show any injury or other traumatic event, the Maryla Examiner must be multiled at page. To Be Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad	e completed) (Gir	cedent's Usual Occupation ve kind of work done during most of work OO NOT use retired) 4P Ply Clark	16b. Kind of Busin Baltime Public	ire Country
ryland nould be file a Mental Hy marked oth natic event	Abraham Da-		Rose	ne (First, Middle, Maiden Surname)	
and 2 st and 2 st saith an n 27 is r	19a. Informant's Name/Relationship (Ty Catherine C. D.	rsey/ Cousin 490		ral Route Number, City or Town, Sta 1 Baltimow Mo	
Baltimore, Separation of Hamoran, Right of Hamonani, Il tiem my injury or other and the and th	20a. Method of Disposition 1 Burial 2 Cremation 3 P 4 Donation 5 Other (Specify)	20b. Place of Dis cemetery, cr	rematory or other place)	Date 20c. Location - City 1-06 Herefore	
Baltin Departmum importantmum partmum	21. Signature of Funeral Service License	99	22. Name and Address of Faulity CF	natman-Harris Fu	ned Home
C m sales	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do not e	ato Reisterstown	or respiratory arrest,	Md 21215 Approximate Interval Between
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	with serger dironle	A	Onset and Death
Examiner	Sequentially list conditions, Tany, leading to firm addate	Dive to (or as a consequence of):			
68760, withcate be executed as the burial-transit edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
68760, filtrate be executed physicien and as the burial-transit edical Examin		Due to (or as a consequence of): f.			
Records, P.O. Box 68 The law requires that the death certificate has been signed by the attending phage 2 should be detached for use as the completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)	23d. Date of Month	delivery Day Year
rds, P quires that nn signed b uid be deta	Part II. Other significant conditions con		underlying cause given in Part I.	23e. Did tobacco use contribut	e to the cause of death? Probably 4 Unknown
				performed? prior death	autopsy findings available to completion of cause of 17's 2 \sum No
rtho f Vital F vsician: The is certificate director, page	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		h (Check only one)	
Division of Vital Retal or Attanding Physician: The state death. The proposition of Vital Retal or Attanding Physician: The state death or Attanding Physician: The state of the state of	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 Yes 2 No	me 5 Residence 6 Other (S 28d. Describe how injury occurred	ipecity) Arguice
Divisic Divisic all or Attand s after death all Director: ad in by the I	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
Hosp 14 hours Fune tely fill	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	ician: To the best of my knowledge date. To the basis of examination and/or it and manner stated.	th annumed at the tune, date and place, nvestigation, in my opinion, death occurr	and due to the eauso(s) and manner red at the time, date and place, and o	as stated, due to the cause(s)
To the within 2 The the comple	29b. Signature and title of certifier		29c. License number	29d. Date signed (Mo	onth, Day, Year)
·3	30. Name and address of person who co	Sexuation hS mpleted cause of death (Item 23a) (Type	D009593		
		32. 6 distrar's Signature	OW LANVILLES	T, Buckinson, 1	DIME
State Registrar	MAY 3 1 201		and a		

		1 - For State Registrar	State of Marylar		artment of H			iene g. No. 2006	16977
Physic	ian	Decedent's Name (First, Middle, Last) Lone	etta Mae Jorda	an			2. Date of Deat Month	h Day Year	3. Time of Death 3:30 P. M
/Med Exami		4a. Facility Name (If not institution, give s			4b. City, Town, or		May	27 2006 4c. County of Death	-
		303 Audrey Aver 5. Social Security Number 6. Sex		last hirthday)	Balt:	imore If Under 24 Hrs	8. Date of Birth		rundel
Funera Director		214 46 1544	IM 2⊠F 58	Yrs.	Months Days	Hours Min.		, 1947 Ma:	ryland
/land		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
ne Mary 8e-f eh	Director	Maryland Anne An	rundel	Baltin					1 ☐ Yes 2 ½ ☐ No
with the		10e. Street and Number 303 Audrey Aven	ue		10f. Zip Code 212	.25	1	0g. Citizen of What Cou U.S.	ntry?
Iryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other then "netural", or items 23a or 28e-f show matic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1	.	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2ሺ No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
5-0036 72 hours af netural, or offeal Exem	eted	15. Decedent's Edu (Specify only highest grade	cation a completed)	16a. Dece	dent's Usual Occupa	ation furing most of wo	rking	16b. Kind of Business/In	dustry
Z1Z15- d within 72 piene. rrthen "ne"	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	life. I	oo NOT use retired etary			Balto. Gas	& Electric
Maryland 2 d 2 should be filed th and Mental Hygi t7 ie marked other traumatic event, II	To Be C	17. Father's Name (First, Middle, Last) E1mer	Rankins				me (First, Middle, M Birch	Maiden Sumame)	
Ma d 2 : d Ith ar		19a. Informant's Name/Relationship (Ty) Richard Jordan /	·		ng Address (Street a .udrey Ave			City or Town, State, Zip Maryland 2	
altimore, M mit. Pages 1 end 3 partment of Health portant: if item 27 y injury or other tr		20a. Method of Disposition 1 XBurial 2 Cremation 3 R	emoval from State	emetery, cren	sition (Name of natory or other place			20c. Location - City or To	
Baltimor permit. Pages Department of important: if it eny injury or o		4 □Donation 5 □Other (Specify) 21. Signatu → Funeral Service Line nse			en Mem. Pa		, =	Glen Burnie eral Servic	
		1136		4	001 Ritch	ie Highw	ay Balt:	imore, Mary	
Physician		23a. Part1. Enter the disease or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat e cause on each line.	A A	er the mode of dying	,	c or respiratory arre		Approximate Interval Between Onset and Death
/Medical Examiner	F	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	Due to (or as a consequence to (or acceptance to (or acceptance to (or acceptance to (or acceptance to (or acceptance to (or acceptance to (or acceptance to (or acceptance to (or acceptance to (or a						
8 / 60, secured cate be executed only sicien and the burial-transit	ical Examin	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
Geath certification of for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
	ed by Pt	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause give	on in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?
The The page	Completed	CARONIL	RENAL	FA	LURF		24a. Was ar autopsy perform 1 Yes 2	24b. Were autoprior to codeath?	psy findings available mpletion of cause of
	Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐	ED/Outration	Othe		ath Check only one		
	on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	3 DOA	at Nursing	28d. Describe ho	nce 6 Other (Specifi w injury occurred	y)
UNISION (I or Attending P after death. Director: After I in by the funera	Icatic	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he		M 1 🗆 Y	/es 2□No	29f Location /Str	eet and Number or Rura	10-11
LIVISION To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	4 Homicide determined	building, etc. (Specif	y) 			City or Town,	State)	
To the Hospitel or within 24 hours afte To the Funeral Dis completely filled in	Medical	29a. Certifier Certifying Phys (Check only one)	ician: To the best of my knower: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and place inion, death occu	o, and due to the ca urred at the time, da	use(s) and manner as si te and place, and due to	ated. the cause(s)
To the within 2 To the complei	W	29b. Signature and title of certified	ai MD		29c. License	number	29	d. Date signed (Month,	2006
り		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, I	Prim	NGTON	VAVE	BALTIN	10 KE
St Regis	ate	31. Date filed (Month, Day, Year) MAY 3 1 2006	32. Registrar's Signa	ture Spark	2			- 6122	Ь

State of Maryland / Department of Health and Mental Hygiene 🛭 🗎 🔓 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2006 **Physician** Month airac HOZHHOL 29, May 10:50an /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7405 Village Road Apt. #8 Sykesville Carroll 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day, Year) May 10, 1936 6. Sex Birthplace (State or Foreign Country)
 MD **Funeral** 157M 2□F Months Days Hours Min. 220-30-5927 70 Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County show 10d. Inside City Limits ral", or items 23a or 28a-f show Director Carroll 1 ☐ Yes 2 ▼No Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7405 Village Road APt. #8 21784 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ∏ No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic svent, I've Madical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Property Mgmt. Company Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ? Johnson Evelvn Powers 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other tra Mrs. Marie B. Johnson (Wife) 7405 Village Rd., Apt.#8 Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Gardens 6/2/2006 Marriottsville, MD 21. Signature of Funeral Service Licensee, HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) buan Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Enysician cancer - metastatio B109912 disease or condition resulting in death) 20month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or minury that initiated events Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, nding physician use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Animia 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 51 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Vithin 24 hours after and To the Funeral Direct To the Funeral Direct To the Funeral Direct To the Funeral Filled in by þ 4 T Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 030573 5-30-06 ND 10 30. Name an ordress of person who completed cause of death (Item 23a) (Type, Print) JOB Little Patoxent Parkway Columbia, MA K. WINFORD. 11065 WD 32 Registrar's Signature 31. Date filed (Menth, Day, Year) 2006 State 2480 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 11 per inf 2859 9-7-06 vt. State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2058 Wanda MAY Kone /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1005 pital eoge' Cheverly 6.0042 rince Vince If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 26, 1 7. Age (In yrs. last birthday)
45 6. Sex Funeral 5. Social Security Number Birthplace (State or Foreign Country) 1 M 2 XF Director 579-90-6927 1960 Washington DC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f ehow DC 1X Yes 2 □ No Directo Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 219 51st St NE 20019 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status - Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d other then " Elementary/Secondary (0-12) College (1-4or 5+) Resturant Manager Private item 27 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental James Woods Laura Cotton 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Cotton /Sister 912 Jansen Ave Capitol Heights MD 20743 f Health 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Metropolitan Crematory 5-27-2006 Alexandria Va Department of H Importent: If ite any injury or ot once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityPope Funeral HOme Signature of Funeral Service Licensee m ano 2617 Penn Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** I monumo deticiency disease or condition resulting in death) Human /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed cate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes. 2 No
920 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed certificate 1 Yes 2 No or Attending Physicien: : After this certific funeral director, 25. Was case eferred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide fo the Hospitel 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Magy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVA Son Sy 31. Date filed (Month, Day, Year) v3Tec 3001 2. Registrar's Signature State Registrar MAY 3 2006

				= For Amend Item#5 Registrar					Mental Hy	giene Reg, No. 2 (01e. 006	16981
		Physici /Medic	al	Decedent's Name (First, Middle, Law WOODROW JOSEPH KI 4a. Facility Name (If not institution, gi	LEIN,SR.		4b. City, Town,	or Location of Death		Day Day 4c. County		3. Time of Death 12:30A M
		Examin	ier	Berlin Nursing &	Rehabilitation		Berli	.n		Worce	ester	
		Funeral Director		0000	Sex 7. Age (In yrs. 1 ☑ M 2 ☐ F 88	Yrs.	If Under 1 Year Months Days		July 2	Th Year 1917	9. Birthp Coun Mar	lace (State or Foreign yland
		filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or iteme 23e or 28e-f ehow ther, the Medical Examinar most be notified at	tor	10a. State 10b. County Maryland Worces		y, Town or Lo	n City				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
		with the	Funeral Directo	10e. Street and Number 157 Nautical Lane			10f. Zip Code 218	142		10g. Citizen of V USA	Vhat Coun	ntry?
		death me 23	neral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.		Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No		e - Americ	
	9030	within 72 hours after death with the Marylan liene. rthen "naturel", or Iteme 23a or 28e-1 ehow The Medical Examinat must be notified at	Ď	1 Never Married 2X Married 3 Widowed 4 Divorced	1 Tyes 2 No If Yes, Give Year or Dates: WW11	-	1 ☐ Yes 2 X No	Specify:		Specify	Wh	ite
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ΜO	р 2		0	17. Father's Name (First, Middle, Las		0001	C COMMITS	18. Mother's Nam			19)	
dr	ylan	D 20 0	To B	George A. Klein					a Brock			
-		ges 1 and 2 should it of Health and Men if item 27 is marks or other traumatic		Phyllis LaPierre	(Daughter)	157	Nautical	Lane Oce	an City	, Md. 2	L842	
ein,	altimore,	Pages 1 ment of H ant: If ite		20a. Method of Disposition 1X□/Surial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Removal from State Ga	rdens		Cem. 6-2		20c. Location - Baltimo 401 Bela	ore,	Md.
Kle	Ball	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Lice	ensee Con sel		2. Name and Adda Lassahn	ess of Facility Funeral H		altimore		
•		Physician /Medical		23a. Part1. Enter the disease, or conshock, or heert failure. List only Immediate Cause (Final disease or condition resulting in death)	mplications that caused the deat y one cause on each line. a. Due to (or as a consequence)	tie C	_	ing, such as cardiac	_			Approximate Interval Between Onset and Death
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	8760,	ate be executed thysicien and the burial-transit	dicai Examin	Cause (Disease or injury that infitated events resulting in death) Last	c	uence of):						
	Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnation to the control of the control o	ıl death 3[□Ectopic pregnan	су			e of delive	ery Day Year
	rds, P.	requires that the de been signed by the should be detached	Ď	Part of Other significant conditions	/ / / //	culting in the u	/-	yen in Part I.		tobacco use cont Yes 2 □ No	ribute to th 3 ☐ Prob	ne cause of death?
	al Reco	: The law rec cate has bee ; page 2 shor	Completed						24a. Was auto perfo 1 Yes	psy ormed?	Were auto prior to cor death?	psy findings available impletion of cause of
	ĬĬ Ĭ	sician s certifi lirector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outnatier	nt 3 DOA	26. Place of Dea		one) idence 6 □Oth	er (Snecifi	v)
	on of	tending Physician: The lav beath. tor: Atler this certificate has the funeral director, page 2	⊢	27. Manner of Death 1 Netural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c Inj			how injury occurs		//
	Divisi	or Attendated after death	ertification:	3 Suicide 6 Could not determine	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	reet, factory, office	3		(Street and Numb wn, State)	er or Rura	l Route Number,
		To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C		Physician: To the best of my known aminer: On the basis of examination and manner stated.							
		To the To the comp	Me	29b. Signaruse anathitle of continer	Much		29c Licer	se number	>	29d. Date rigner	101	
	7	14		30 partie and address of person wh	o completed cause of death (Item	T,23a) (Type,	Print) /20	9 Court	el Heile	ever 1	Enu	x ch 7- (200);
		St: Regist	ate rar	31. Date filed (Month, Day, Year) MAY 3 1 2	Registrar's Sign	ture Age	will		1	7		

			1 - State Registrar	ate of Maryland / Dep	partment of He partificate of L			ene 0 0	6 698
	Physici	an	Decedent's Name (First, Middle, Last)	3.6.0			Date of Death Month		3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give stree	EISER	41. 63. 7	Landing of Dank	May 28,	2006	1:00P ^M
	Examin	er	Oak Creat Care Cent	•	4b. City, Town, or Parkvi			4c. County of I	imore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	v) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
п	Director		213-03-7758 154	2□ F 93 Yrs.	Months Days	Hours Min.	April 1	1,1913	Maryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	Maryl f sho	tor	Maryland Baltimore						1 ☐ Yes 2 🔀 No
	r 288	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wha	t Country?
	th with		8800 Walther Blvd	•	21234			U.S.A.	
	r dea	Funeral	A	Vas Decedent Ever in U.S. 13	B. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
36	ours after death with the Marylan rair, or Itams 23a or 28a-f show	by Fu		☐ Yes 2 No Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
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7	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ather than "natural", or Itams 23a or 28a-f show nit. It a Modelle at a miner must be notified at mark the motified at the Modelle	Com	11yr's		P. of Con	tracting		Port of	Baltimore
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Maryland 21215-0036	2 should be filed within and Mental Hygiene. is marked other than sumatic avant, Italy	To	Michael 19a. Informant's Name/Relationship (Type, F	Keiser, Sr.	iling Address (Street a	Dora	J Doute Number	August	
	and 2 s lealth an m 27 ia her trau	,	Mrs. Dorothy Dernag		0 Prospect				, MD 21638
timore,	of Head of Hea		20a. Method of Disposition	20b. Place of Dis	·			Oc. Location - City	<u> </u>
Ĕ	Pages nent of it ant: If itu		1 🔀 Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	Val ITOITI State	ood Cemeter		6 B	altimore	. MD
Balt	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service Licensee		22. Name and Address	-4 E30b	ltimore,		
	0 0 5 € 0		Paul L. North	not y	Leonard J.	. Ruck, I	nc. 530	5 Harfor	d Rd.
			23a. Part1. Enter the disease, or complicatio shock, or heart failure. List only one ca Immediate Cause (Final	ns that caused the death. Do not e use on each line.	nter the mode of dying	, such as cardiac o	r respiratory arres	it,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Sybarach	inord N	emorr	haze		
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Division of	ding Ph th. : After thi funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	a. Date of Injury (Month, Day Year) 28b. Time		at 2	8d. Describe how		
<u>S</u>	uttendi death. ctor: A y the fu	catl	2 Accident investigation			es 2 No			
\leq	if or Attence after death Diractor:	Certification:	4 Homicide determined 28	 Place of Injury - At home, farm, s building, etc. (Specify) 	treet, factory, office	2	City or Town, S	et and Number or State)	Rural Route Number,
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	To the Hospital or Attending Phyaician: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Exeminer: (On the basis of examination and/or i and manner stated.	nvestigation, in my opi	nion, death occurre	ed at the time, date	and place, and	due to the cause(s)
	With To t	Σ	29b. Signature and title of certifier	\wedge	29c. Lidense	number	29d	. Date signed (Me	onth, Day, Year)
			1 2/100		W 1)	27241		30/6) L
_	15		30. Name and address of person who complete Brunning	ted cause of death (Item 23a) (Type	() (7)	- Blud	faul	cville!	4621234
	Sta Registr	· 18	31. Date filed (Month, Day, Year)	32. Registrar's Signature	mark !				

ORIGINAL

	Director		Kavive street and numb	wahara Der) . Age (In yrs. 90	last birthday)	·	Town o			Date of Dea Month May 2	7, Day 20	06 Year	3. Time of Death
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irector	Director	5. Social Security Number 6. 551-18-0596 Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo	1 X M 2□F		last birthday)	T	imon	ium			Ba	ltimor	e
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1	e	2320 Foxley Road					2109	3			Unit	ed Sta	tes
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or ite	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forc 1 Tes 2 If Yes, Give Year or Date	XN0		r ves, spe 1 □ Yes		Specify:	иепо н	can, etc.)	Sp	Black, White ecify:	sian
Stura En E		15. Decedent's I			16a, Deced	dent's Usual Occupation 16 kind of work done during most of working					16b Kind	b. Kind of Business/Industry	
an un	Set	(Specify only highest g	rade completed)		(Give	kind of wo	ork done o	during most of	working	,		ed Sta	*
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mari	2	19a. Informant's Name/Relationship			19h Mailin	a Addres	s /Stroot			Route Number	City of To	Ctato 7	in Codel
7 is trau													p Code)
other traumatic	ŀ	Karen L. Goins, 20a. Method of Disposition	Daughter	20b. P	_6115 F	ores	me of	e Court	C, C	olumbia		21045 ion - City or T	Four State
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tant		4 □ Donation 5 □ Other (Spec	7	Wes	st Arur								ryland
Important: if ite any injury or ot once.		21. Signature of Funer Service	nsee	M011				ss of Facility P.A.					L Services on, MD 21093
sician edical		23a. Part1. Enter the disease, of cor shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on eac	n line.	Cashia	()	Car	Hon					Approximate Interval Between Onset and Death
/sicie	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of a consequence of a conse	106	0(- h	clf	CONIC	. Q.	slu L			
as th													
igned by the attending be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ∏Feta ntattime of di	death 3	Ectopic p Other (s _f					23d.	Date of delive Month	very Day Year
deta deta		Part II. Other significant conditions	contributing to deal	th but not resi	ulting in the ur	nderlying (cause dive	en in Part I		23e. Did tol	pacco use o	contribute to	the cause of death'
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ral di	-	1 Yes 2 No			ER/Outpatient 28b. Time of		OA 28c. Injury	4 🗆 1401311	-				fy)
or: After	ation	1 Natural 5 ☐ Pending investigate		Day Year)	Injury	м	Work	rat (? Yes 2 □ No	200	d. Describe ha	w injury oc	curred	
To the Funeral Director: After the completely filled in by the funeral.	Certification:	3 Suicide 6 Could not 4 Homicide determine	4 289. Place of	f Injury - At ho , etc. (Specify	ome, farm, stre	eet, factor	y, office		281	Location (Sta City or Town		umber or Run	al Route Number,
Funer etely fill	edical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the building the basing and manner	is of examinat	wledge, death tion and/or inv	occurred estigation	at the time n, in my op	e, date and pl pinion, death o	lace, and	d due to the ca at the time, da	use(s) and ate and place	manner as s ce, and due t	itated. o the cause(s)
omp	Ž -	29b. Signature and title of certifier	A .				c. License		-			gned (Month,	Pey, Year)
,		•	10	m			0	1562	32	- Su		- / -	1 0
6		30. Name and address of poon who	cause	of death (Item	23a) (Type, i	Print)	(A	no do	01) (6.01	17 (poles N

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

MAY 3 1 2006

32. Registrar's Signature

Amend item#9, perfff, (357, 7/17/06 TI State of Maryland / Department of Health and Mental Hygiene) For State Registrar Amend Item #15 Per FH C855 59911/16/21900 Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SAMUEL 10:57 PM LAMBERT 2006 Mai 24 /Medical 4a. Fecility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Balhner Medical Baltimore Mercy If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 9. Birthplece (State or Foreign Countribaltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 12M 2□F 220-30-069 Director 36 6 Usual Residence of Decedent 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits or 28a-f ahov other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No mp Completed by Funeral Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 West or Items 23a APT 508 U.S 2120 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Depertment of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or Item any injury or other traumatic event, the Market and Once. 1 Never Married 2 Married 1 Yes 2 No Specify: Black If Yes, Give Year or Dates: Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **4** 12 - N/A ustodia 705 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Shater Ella 6 eorge Lambert ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Lamber West APT 508 Balts. 2/201 Conway mD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Green mount 31-06 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BeTTS Funeral Hone atrices Balt.mD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) non-small all ling cause metastatic **Physician** 6 monte /Medical Examiner superior vena cara sepuchosus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ŏ Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s autopsy performed certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation 2 No death. if Director: / 1 Yes 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Attending 30. Name address erson who completed cause of death (Item 23a) (Type, Print) J. NYZAULN, NID 301 ST. Paul ST. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 3 1 2006 Registrar

			1 - For State Registrar		State of	Maryland		artment of <i>tificate o</i>			Mental Hy	/giene Reg. No	~ UUU	16984
	Physici	an	Decedent's Name (First, M	iddle, La	,	\/ 10.	- N144				2. Date of D Month	Oa		3. Time of Death
	/Medic		4a. Facility Name (If not institu	tion give		Van Mo	SNUTT	4b. City, Town	or Loon	tion of Doeth			7, 2006 County of Death	2:53 p M
	Examin	er			of Baltimo		+)	40. City, TOWN	, or Local	Baltir		40		more
	Funeral		5. Social Security Number	6. S		7. Age (In yrs. la	/	If Under 1 Yea		nder 24 Hrs.	8. Date of B	irth		inplace (State or Foreign intry)
ı	Director		075-22-5301	1	M 2□F	84	Yrs.	Months Day	's Hou	urs Min.	(Month, D	ay, Year) 7, 192		ew Jersev
	p ,		Usual Residence of Deceden 10a. State 10b. Cou			10. 01.	Ŧ							
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	ns 2	Funeral	11. Marital Status	- 7 (10)		dent Ever in U.S	S. 13. V	Vas Decedent o			ecify Yes or N	0-	14. Race - Amer	
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, Maryland	is 1 and 2 shot Health and item 27 is nother treun		19a. Informant's Name/Relati		Type, Print)			g Address <i>(Stre</i> 09 Woodb					or Town, State, Zi and 21239	p Code)
altimore,	of Her of Her litem		20a. Method of Disposition			1 00	ace of Dispos	sition (Name of natory or other p	lace)	1	Date	20c. Lo	ocation - City or T	own, State
<u>E</u>	Page nent ent: H		1 🔀 Burial 2 □ Cremati 4 □ Donation 5 □ Othe			tate		stern Ceme			06/01/06		Baltimor	e, Md.
Balt	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other ottes.		21. Signature of Funeral Serv	ice Licen	1/ M	1000	R P2	Name and Add		-	al Service altimore, M	P. A.		
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2	or A after Direction by	Certification:	4 ☐ Homicide det	ermined	building	g, etc. (Specify)	ie, farm, stre	et, factory, office	•		City or To	street and wп, State,	d Number or Rum)	il Houte Number,
	spite ours neral filled		29a, Certifier 1 Certi	ying Ph	ysician: To the b	est of my know	ledge, death	occurred at the	time date	a and place	and due to the	cause(s)	and manner as s	tated
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Physician /Medical Examiner		. Decedent's Name (First, Middle, La									eg. No. 🚐 🖔	The Party of the P	1 30 0
Examiner			Co.	tle F	R. Linto	n				2. Date of Deat	h Day	2006	3. Time of Dec
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Funeral Director		406-34-4285	6ex 7. Ag 1 □ M 2 🖫 F	je (In yrs. 94	last birthday) 4 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day, Jun 7,	Year)		ace (State or Fo try) Centucky
f show	1	Isual Residence of Decedent Oa. State 10b. County Maryland	N/A	10c. Cit	y, Town or Lo	cation	В	altimore				10	0d. Inside City L
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Department of Health and Mental Hygiene. Important: If tem 27 Ie marked other then "natural", or items 23a or 28a-f ehow appriant; If item 27 Ie marked other the "healtest Examinat must be restitied at once. To Be Completed by Funeral Director	1	1. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			1 □ Yes	2)(No	ispanic Origi n, Mexican, Specify:		ecify Yes or No- Rican, etc.)	Spe	lace - America llack, White, e	an Indian, etc. Black
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27 le ma		9a. Informant's Name/Relationship (Joan O'Hara	Type, Print)							al Route Number, e, Maryland		vn, State, Zip	Code)
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eng of	· P	art II. Other significant conditions of	contributing to death b	ut not resu	ulting in the un	derlying ca	ause give	n in Part I.			acco use co		cause of deat
rtificete has been si ctor, page 2 should I										24a. Was an autopsy perform		prior to com death?	sy findings ava pletion of caus
this certific al director.	1	5. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital:	ent 2 🗆 I	ER/Outpatient	3□ DO	A Othe			Check only one	-	ther (Specify)	
the funer cation;	27	7. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b		y Year)	28b. Time of Injury	М	Bc Injury Work 1 □ Y	at ? ′es 2 □ No	5	28d. Describe how	v injury occi	urred	
urs effect oral Direct lled in by		4 Homicide determined	building, et	c. (Specify	′)					28f. Location (Str City or Town,	State)		
within 24 hours of To the Funeral D completely filled in	2	9a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exar	nysician: To the best niner: On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred a estigation,	in my op	e, date and inion, death	place, a occurre	and due to the car ed at the time, da	use(s) and n te and place	nanner as sta e, and due to t	ted. he cause(s)
To To To To To To To To To To To To To T		9b. Signature and title of certifier O. Name and address of person who	nama completed cause of d	eath (Item	23a) (Type. F	29c.	License D4	number 710	3 1E	29 1 1	d. Date sign	24 HOSPI	ay, Year) 200

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. -

Year

DHMH 17 Rev 1/2001

State Registrar

arve

1 - For State Registrar

219 S. Washington Street, Easton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

32 Registrar's Signature

David Smith,

31. Date filed (Month, Day, Year)

			1 - State State Registrar	of Maryland		tment of He			ene	16	169	87
	Physici	an	Decedent's Name (First, Middle, Last) John E. Lombardo					2. Date of Death Month May 27,		Year	3. Time of	
	/Medic		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or I	Location of Death		4c. County		11:05	Рм
	_xaniii	iei	Hospice of Baltimore G	ilchrist C	enter	Towson			Balt		•	
	Funeral Director		5. Social Security Number 217-12-8234 6. Sex 1 2 M 2	7. Age (In yrs. las 81		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug. 25,	1924	9. Birthp Cour Mary	lace (State of Tand	Foreign
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Fown or Loca	ation				1	0d. Inside Cit	y Limits
	e Mar	Director	MD Baltimore	Tows	on						1 🗌 Yes	2 X No
	with th		One Smeton Place #130	1		10f. Zip Code 21204)g. Citizen of V SA	Vhat Cour	itry?	
	death ms 23	Funeral	11. Marital Status 12. Was D	Decedent Ever in U.S.	13. W	as Decedent of His Yes, specify Cuban	panic Origin? (S		14. Rac		an Indian,	
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Items 23a or 28s-f show aumatic event, the Medical Eval., arring the molified at	by Fur	1 Never Married 2 Married 1 NY	1 Forces? es 2 ⊡ No , Give	i	V	, Mexican, Puert Specify:	o Hican, etc.)	Specify	k, White,		
-002	2 hours		15. Decedent's Education	or Dates:	16a. Decede	nt's Usual Occupat	tion	1	6b. Kind of Bu	WI	i te	
7 2	ithin 72 18. 18n "na	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) College 12	ed)	(Give ki life. D	nd of work done du O NOT use retired)	iring most of wor	king			·	
7	iled will Hygien ther ther the		17. Father's Name (First, Middle, Last)		Sales		18 Mother's Nan	ne (First, Middle, M	Life Ir		nce	
and	lid be f lental h ked of Ic eve	To Be	Philip B. Lombardo				Elvira		aloen Sumam	6)		
ary	shou and M is mar	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Street ar	nd Number or Ru	ral Route Number,	City or Town,	State, Zip	Code)	
≥ O	1 and 1 1ealth 9m 27 ther tr		Loretta S. Lombardo / 20a. Method of Disposition			neton Pla	ce #1301	: Towson	MD 2]		- Ctata	
	ages ant of th it: If Ite y or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fr '4 ☐ Donation 5 ☐ Other (Specify)	om State cem	etery, crema	itory or other place,	6/1/		wings N			
Daitimor	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic es		21. Signature of Funer I Sarvice Libensee			Name and Address			1050 \			_
٥	8818		1 Jetu Very	/		k Towson			Towsor	, MD		
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause of immediate Cause (Final	at caused the death. I on each line.	Do not enter	the mode of dying,	, such as cardiac	or respiratory arre	st,		Approximate Interval Betw Onset and D	een
	Physician /Medical		disease or condition resulting in death)	to (or as a consequer		cer				,	months	
	Examiner											
-	7847 Tg	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consequer	nce of):							
<u>.</u>	execut n and ial-trar	Examiner	that initiated events resulting in death) Last C. Due	to (or as a consequer	nce of):							
	cate be executed bhysician and the burial-transit	dical	d									
0 X O	death certifics a attending pl d for use as t	/Med	IF FEMALE: 23c If yes	outcome of pregnancy	u .							
מ	death death death death death	Physiclan/Me	in the past 12 months?	ve birth 2 🗍 Fetal de egnant at time of deat	ath 3□E	ctopic pregnancy Other (specify)			23d. Date Mor	of delive oth	,	ear
5	at the	hys	9 ☐ Unknown	nknown				-				
cords,	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the luneral director, page 2 should be detached for use as the burial-transition.	þ	Part II. Other significant conditions contributing t	o death but not resulting	ng in the und	erlying cause giver	n in Part I.	1	acco use contr 2 No	ibute to th		
בי	The law r te has be	Completed				_		24a. Was an autopsy perform	D	rior to con eath?	osy findings and pletion of car	variable use of
N I G	ertifica octor, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea	1 ☐ Yes 2 th (Check only one			5 6 No	
5	Physic this c	T.			Outpatient	3 □ DOA Other	4 Nursing H	ome 5 Residen			Hos	PICE
5	nding tth. :: After	atlon	1 Natural 5 Pending 2 Accident investigation	fonth, Day Year)	Injury	Work?	es 2 No	Eco. Describe not	v injury occurre	, u		
I NISIOIS	r Atter	Certification;	3 Suicide 6 Could not be 28e. Pl	ace of Injury - At home uilding, etc. (Specify)	a, farm, stree	t, factory, office		28f. Location (Stree City or Town,	et and Numbe State)	r or Rural	Route Numb	Θ <i>r</i> ,
ב	pital o											
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certification between the funerel director.	edical	29a. Certifier (Check only one) 1 Certifying Physician: To 2 Medical Examiner: On the and m	the best of my knowle e basis of examination nanner stated.	and/or inve	stigation, in my opi	n, date and place, nion, death occui	and due to the cau rred at the time, dat	ise(s) and mar e and place, a	nner as sta nd due to	ated. the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier		·	29c. License			d. Date signed			
			30. Name and address of person who completed of	MD		D 006	1199	0	Mayio	28.	2006	
	15+1		30. Name and address of person who completed of	ause of death (Item 23	Ba) (Type, Pr	int) 66011	ON HAR	D 21209	ET j			
	Sta	te		Aegistrar's Signature	9	.00 n	, , ,		,			
	Registr	ar	-MAT 3 1 2005	13811 B	Sico	SL)						

Lombardo, John

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Mckinstry Lerby 2006 5:10 M 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death university SPECIALIY MA Baltimore HOSPITAI If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 24.64.0461 Hours 1 M 2 ☐ F 50 Director 10.08.1955 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene.
ant: If item 27 is marked othar than "natural", or Itams 23a or 28a-1 show art; or or other traumatic evant. It was a call Examinat must be neithed at Baltimore Director Joppa 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 21085 Nosling USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker Motors 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) McKinstn, 8r. Alberta Chiles Levou 19a. Inform of s Name/Relationship of e, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rossing Way Jopa MD 21085 20c. Location - City or Town, State Vebra 303 Jppa 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place) 1 ■Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or 06/02/06 4 ☐ Donation 5 ☐ Other (Specify) Garnson Forest 21. Signature of Funeral S. rv. e Licensee 22. Name and Address of Facility Funeral Services taughn C. Crene Funeral Services 4905 tork Road Baltimone MD: 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of Examiner 5 m erebrovasular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit 5 m Due to (or as a consequence of): Box 68760. NA IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death NIA 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HIV AIDS page 2 should Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 ☐ Yes 2 9 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examine Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After NIA 1 Natural 5 Pending death. M 1 ☐ Yes 2 ☐ No after death Diractor: / 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number teaun-3 MD 00050480

Registrar

DHMH 17 Rev 1/2001

S. Char

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Baltimore

MD

NES, 601

A Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZERA-YOHAN

31. Date filed (Month, Day Year) 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:48PM Roberta Mancuso 2006 May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1 Brett Court Essex Baltimore Apt. 201 H Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Jan 11, 1933 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 73 Yrs. Director 218-28-6977 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits itam 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Modical Exam art must be notified at 1 ☐ Yes 2 ☑ No Maryland Baltimore Directo Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Brett Court Apt. 201 21221 **USA** Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 XDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 end 2 should be filt Depertment of Health and Mental Hy Important: if Itam 27 is marked oth any injury or other traumatic avant 9DE8: Be Joseph Hodges Madeline Stein 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iris Holthaus, Daughter 1562 Alconbury Road Essex, Maryland 21221 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Crematory Inc. 05/30/06 4 □Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signalure of Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Consestive **Physician** Heart /Medical Due to (or as a consequence of): Examiner portemine Cardio vascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Atrial Fibrillati The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and does detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No peen upucute puckerial andocarch is 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? GI certificete 2 No 1 ☐ Yes 2 ☐ No 1 Yes director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) uden 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sholden Milner, MN 9/10 F Philadelphia Rd 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

			State of Maryland / Dep	artment of Health and N		4000	16990
	* 5	30	Decedent's Name (First, Middle, Last)	Timodio or Dodin	2. Date of Death		3. Time of Death
	Physici		Charles A. McGinn		May 25,	2006 Year	9:30 ам
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		Ξ.	6809 Youngstown Ave.	Dundalk		Baltim	ore
a g	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 26, 1		place (State or Foreign
	Director		212-01-9259	Mortus Bays Hours	Aug. 26,1	906 M	d. <u> </u>
7	* *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
, local	sho and	ō	Md. Baltimore Dundalk				1 ☐ Yes 2 No
d d	289-1	Director	10e. Street and Number	10f. Zip Code	10a.	Citizen of What Cou	ntrv?
, in	JO SE			21222		USA	,
400	79 2	Funeral	6809 Youngstown Ave. 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Splf Yes, specify Cuban, Mexican, Puerlo	ecify Yes or No-	14. Race - Ameri	
0	or Itan		1 ☐ Never Married 2 ☐ Married	If Yes, specify Cuban, Mexican, Pueric 1 Tyes 2 No Specify:	Rican, etc.)	Black, White,	
5	nous arer deam with the maryand turel, or teme 23a or 28e-f show at Exemitrer must be notified at	ρ	3X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 LIYes 243 No Specify:		Specify: *****	
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2	then "na	μ	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) olling Mill Superv	icor	Steel	
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ลา	ntal h	Be	Charles H. McGinn	Unknown	o (* no., madio, mai	John Carriamo,	
Maryland	and Men and Men amarke	ပို	And the second s	ing Address (Street and Number or Rur	al Route Number. Ci	tv or Town, State, Zii	Code)
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Baltimore,	f Health		20a. Method of Disposition 20b. Place of Disposition cemetery, cre-		Date 20c	. Location - City or To	own, State
٤	ment of tants of tants If It		1 Burial 2 ACCemation 3 Hemoval from State	Crematory May	26 2006	Baltimore	
= ==	글론원은			2. Name and Address of Facility Connelly Funeral Ho	ome Of Dur	ndalk	
m :	Depa Impo		Carend 11	110 Sollers Point	Rd. 21222)	
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	/Medical		resulting in death) Due to (or as a consequence of):	heart failu artery dike y Bladder Co		-/-	10-40
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147	g ts	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C	n Rladd / C	211501	-	3 months
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Вох	nding use a	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	NA		23d. Date of deliv-	ery
ă	atte d for	cla	in the past 12 months? 1 Vec. 2 No. 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
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Records,	w require been sig should b		-7 Diaverses		1 🗌 Yes	2 □ No 3 Prot	pably 4 ∐Unknown
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Ĕ,	ysician: The is certificate ha director, page	Com	- Peripheral Vaseular a	isease	performed 1 ☐ Yes 2 🔀	? death?	
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בו	After	i o	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)	Work?	28d. Describe how in	njury occurred	
Sic	death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be 289 Place of Injury. At home farm si	M 1 Yes 2 No	28f Location (Stmo)	t and Number or Rura	al Pouto Number
Division of	after after Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	rest, ractory, onics	City or Town, Si		ar noute ivanioes,
	spire ours rerel filled		29a. Certifier 1½ Certifying Physicien: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the cause	e(s) and manner as s	tated.
	To the hospitel or Atsnating Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled Infector: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only 2 Medical Exeminer: On the basis of examination and/or in one)	nvestigation, in my opinion, death occur	red at the time, date	and place, and due to	o the cause(s)
	To th To th	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
, '			Maloum Z. M. Kamo, M	2057061		05/26/	06
	1		30. Name and address of person who completed cause of death (Item 23a) (Type		.10		. N = 1= =
	1		MOHAMMAD.M. RANAMO. 4920-	CAMPBELL BLU	d, BACT	IMORE, K	1221236
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1			
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 3 1 2006

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Pnysic /Med Exam	lical	1. Decedent's Name (First, Middle, La MELVIN 4a. Facility Name (If not institution, gin Harbox Hospitz	re street and number)	MIELK	1	- /	Location of Death	2. Date of De Month Mag	Day 28 4c. Coun	2006 ty of Death	3. Time of Death 5132 AM
Funera Directo		5. Social Security Number 6.		e (In yrs. last birthda) 81 Yrs.	Months	or 1 Year Days	if Under 24 Hrs. Hours Min.	8. Date of Bird Month Da Dec 15	, 1924	9. Birthp Cour Mary	lace (State or Foreig try) Land
ne Maryland 8a-f show	Director	Maryland N/A		10c. City, Town or I	Balti						0d. Inside City Limits
with the		10e. Street and Number 4106 Grace Court				ip Code 21226			10g. Citizen o	f What Cour USA	itry?
Ilfilmore, IMaryland 21215-UU36 int. Pages 1 and 2 should be filled within 72 hours after death with the Maryland artment of Health and Mental Hygiene. orian:: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Madical Evantinal the Invitibal at a constant the profile of the contract of the	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 1 Yes, Give Year or Dates:			edent of His ecify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		ace - Americ ack, White, ify: Whi	etc.
Z 1 Z 1 S-U 1 within 72 ho jiene. r than "natur the Medicel j	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	(Giv	edent's Usi e kind of w DO NOT	ual Occupa ork done di use retired)	tion uring most of work	sing	16b. Kind of	Business/Ind	-
Maryland 21215-0036 d 2 should be liled within 72 hours at lith and Mental Hygiene. 77 Is marked other than "natural, or traumatic event, the Madical Event traumatic event, the Madical Event	To Be C	17. Father's Name (First, Middle, Last Unk. Mielke					18. Mother's Nam Myrtle	Unk.			
ealth and markealth and markealth and markealth and markealth and markealth and mertraum	4	19a. Informant's Name/Relationship Mary E. Mielke,					n <i>d Number or Rur</i> ırt Balti				
Baltimore, bernit. Pages 1 ar Department of Hea Important: If item: May injury or other		20a. Method of Disposition 1 Burial 2 X Cremation 3 [4 Donation 5 Other (Special Contents)	Removal from State	20b. Place of Disposementary, com	osition (Na	ame of other place)	Date	20c. Location	- City or To	
Baltimo permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Lice Inomas Gregor			Crema 299 F	tion reder	Society ick Road	Of Mary Baltim	land In	nc. arylar	d 21228
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ate be executed and hysicien and hysicien and he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (A as	a consequence of): 2 mil a consequence of):	Phei	s	Nigor				Hours
death certific attending p	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic p □ Other (s					ate of delive	ry Day Year
F 5 5 5	by	Part II. Other significant conditions Chronic Obsta		ut not resulting in the		cause giver	n in Part I.	23e. Did to			e cause of death? ably 4 □Unknown
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Hosp 24 hou Funer stely fill	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/or i	th occurred nvestigatio	d at the time n, in my opi	e, date and place, nion, death occur	and due to the or red at the time, or	ause(s) and n late and place	anner as sta , and due to	ated. the cause(s)
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241		30. Name and address of person who Ahmad Mahall		South Ha	Print)	r Str	cet, B	altimore	2,MD	212	125
. S Regis	tate trar	31. Date filed (Month, Day, Year)		ar's Signature	besti						

Fichard McGee

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			For State Registrar	State of Marylan		ment of Helicate of L		Mental Hygi	ene	
3.	**** 8. **		Registrar 1. Decedent's Name (First, Middle, Las	?)	Certin	icate of L	Jeani	2. Date of Death	3. No. 2 0 0 (3. Time ol-Beath
	Physici /Medio		RICHARD	MCGEE				Month	24, 200	36 3:15 M
	Examin	er	4a. Facility Name (If not institution, give	~ 1	4b	o. City, Town, or	Location of Deal		4c. County of De	ath
	Funeral	£	5. Social Security Number 6. Se	x 7. Age (In yrs.		Under 1 Year	17 Mor	8. Date of Birth	9. B	rthplace (State or Foreign
	Director		916-24-4051 1 Usual Residence of Decedent	YM 20 F 79	Yrs.	onths Days	Hours Min.	Marchi	5,1927 M	ary land
	hours after death with the Maryland turet', or Items 23a or 28a-f show al Exeminat must be notified at	7.	10a. State 10b. County		y, Town or Localid	1 4				10d. Inside City Limits 1 Yes 2 No
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28a-f show other traumatic event, the Medical Examinar must be notified.	Director	10e. Street and Number	2		TIMORA Of. Zip Code		10	g. Citizen of Whal C	
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	er dez Items	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces? 1 WYes 2 ☐ No	S. 13. Was	Decedent of His s, specify Cubar	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
036	ours aft rat', or Exem	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	10	Yes 2 No	Specify:		Specify:	slack
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Maryland	should be nd Mental marked (umatic ev	မ	Shade Mc 19a. Informant's Name/Relationship (7)	(Tee ypo, Print) WIFE	10h Mailine A	ddraes (Carant	IS	abelle	Mc	Gee
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Baltimore	permit. Pages Department of Important: If I eny Injury or once		21. Signature of Funeral Service (Icen:	588 / D	22 Na	me and Address	RES F	ungral 140)
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Вох 6	eath certificate be exer attending physician ar for use as the burial-t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, oulcome of pregna					23d. Date of de	slivery
Ö.	The law requires that the death certificate be exe ate has been signed by the attending physician a page 2 should be detached for use as the burial-	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		opic pregnancy ner (s <i>pecify</i>)		=	Month	Day Year
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ion	ath. or: Afte	atio	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury I		? es 2 □ No			
Division of Vital Records,	or Atte efter de Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, larm, street,	factory, office		28f. Location (Stree City or Town,		ural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funerel Director: Affer this certificate has completely filled in by the funeral director, page 2:		(Check only 2 Medical Exem	sician: To the best of my knowiner: On the basis of examinat	wledge, death occition and/or investi	curred at the time	a, date and place	, and due to the cau	se(s) and manner a	s stated.
	To the Ivitin 24	Medical	one) 29b. Signature and title of certifier	and manner slated.		29c. License			I. Date signed (Mon	
	⊢ ≱ ⊢ 8		> PUEDAMI	Mo		D470	134	Mo	tu) U	2006
	5		30. Name and address of person who o	ompleted cause of death (Item	23a) (Type, Print	0, 0	trimon	7 AA 7	13.0	20-0
6	Sta	te	31. Date filed (Month, Day 3 ear) 20	Registrar's Sign	> / VIV	16:18	1011/WOA	10 /VU) 7	111	
	Registr		MAT 7 70	TO SURGES FO	19					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** samuel Middlebrook Month Year 1ey 1. 45 PM 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Ba If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 102(HOSPITAL Harbor Center Baltimore City 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funeral 1**⅓**M 2□F Director 213-26-0636 May 6, Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ith and Mental Hygiene. 27 ie marked other than "natural", or Items 23a or 28a-f ehow traumatic event, the Medical Examinar must be netified at 10d. Inside City Limits Maryland Anne Arundel Glen Burnie Director 1 ☐ Yes 2/CXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 307 Wilson Blvd 21061 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1951— 1 ⊡Yes 2 □ No If Yes, Give Year or Dates: 1953 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Builder Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Collins Harry Middlebrooks 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i Doug Middlebrooks / Son 903 Genine Drive Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 1, 20c. Location - City or Town, State Depertment of P tmportent: if ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □Donation 5 □Other (Specify) Crownsville MD Vet. Cem. 2006 Crownsville, MD 21. Signature Funeral Solvice Licensee 22 Name and Address of Facility
Kirkley-Ruddick Funeral Home P.A. MD 21061
421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death sepsis Physician 2 weeks /Medical Due to (or as a consequence of): Examiner 2 weeks neumonia Sequentially list conditions, 1 ay leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events o (or as a consequence of): The law requires that the death certificate be executed Exam resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by. Division of Vital Records, 4 Unknown Completed 2 No 3 Probably 1 Tyes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 1 Yes 1 ☐ Yes 2 ☐ No 2X No Attending Physician: director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this within 24 hours efter death. To the Funerei Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, HE 300 Hanover MING South 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:57PM Month 5 Day **Physician** Charmaine McKim 5 06 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Square 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 7tranklin HIMORE 9. Birthplace (State or Foreign Maryland 8. Date of Birth (Month, Day, Year) June2, 1936 Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 1 F 69 216-32-2983 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at Baltimore MD Baltimore 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 718 Clover Ave. 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🙀 No 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Metro Foods el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cashier 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fit tment of Health and Mentel H tant: if Item 27 is marked otl George Jarrett Barton Doris Bortner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: if Item 27 is any injury or other trat s000. 718 Clover Ave. Baltimore MD 21221 William R. McKim /husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Gardens of Faith 1 Burial 2 □ Cremation 3 □ Removal from State Rossville 5/30/06 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee onn Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner evere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death signed by the end to 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, pege 2 perform 2□ No 1 ☐ Yes 2 🖃 No 1 ☐ Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.
To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Hospitai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 0063 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRanklin 9000 Square dr. Baltimore, MD 21237 Massin DR. Monamed 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 3 1 2006 Registrar

harmaine

Please Type or Print in Black Indelible Ink
Manyland / Department of Health and Mental Hy

ason VV. Worga		1- For State Registrar Certificate of Death		eg No 2 1	06 1699
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle, Last) Jason W. Morgan	2. Date of Dea Month May 28, 2		3 Time of Death 0710 hrs
e de la constante de la consta		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dec	ath	4c. County of Dea	
)		Franklin Square Hospital Rosedale		Baltimore Co	•
Funeral Director		1 X M 2 F 3 1 Yrs.	Airo.	15,1975	eian
any	ŀ	Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ō	MD Baltimore Essex			1 Yes 2 X No
ith the Maryland 23a or 28a-f sho	I Director	10e Street and Number 815 N. Marlyn Ave. 10f Zip Code 21221		0g Citizen of What Co USA	ountry?
r death w or items must be	Funeral	11. Marital Status 1 Never Married 2 Married 1 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		14. Race - Am White, etc.	erican Indian, Black, ite
hours afte 'natural'', Examiner	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use in the control of t		16b. Kind of Busines	
5-0036 led within 72 he Tygiene other than "n:	Completed	Elementary/Secondary (0-12) 9th College (1-4 or 5+) Painter	etirea)	Home Imp	rovement
21215-0036 suld be filed within 7 Mental Hygiene marked other than	Be	John W. Morgan Vic	me (First, Middle, l ky Whea	lton	
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Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		20a. Method of Disposition 1 Burial 2 **Cremation 3 Removal from State Bayview Crematory 6 4 Donation 5 Other Specify: 6	Date / 2 / 0 6	20c. Location - City Baltimo	
Baltimore permit Pages 1 Department of 1 Important: If		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	300 Mace	e Ave. Ba	lto. MD
Physician		23a. Part I. Enter the disease, or complications that caused the death. Direct enter the mode of dying, such as cardiac failure. List only one cause on each line.		est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Narcotic (Methadone) intoxication and cocain Due to (or as a consequence of):	ie use		Death
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760, icate be execu physician an	Medical	X UNPENDED 1tem#23a,27,28a-f,perME,g857,76/06	TT		
ox 68 eath certif : attending for use as	Physician/IV	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown	gnancy	23d Date of deliver	ory Day Year
ires that the disigned by the signed by the leached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to	to the cause of death?
Division of Vital Records, P.O. tal or stending Physician: The law requires that the ris after death. To Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Completed		24a. Was	an 24b. Were a	autopsy findings available ocompletion of cause of
Reco The law cate has	Com		perfo 1 Y es	rmed? death? 2 No 1	parameter .
ital Rec ician: The s certificate rector, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nur.		Residence 6 Oth	
of Vit ding Physic After this	2	1 ✓ Yes 2 No 27. Manner of Death 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?		now injury occurred	er
ion tendin eath. for: A	atior	Natural 5 Pending /28/2006 6:15 am 1 Yes 2 No	unk		
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the f	Certification:	3 Suicide 6 X Could not be determined (Specify) residence at home		Street and Number or F tate 15 N. Mari	Rural Route Number, City 1yn Ave.
To the Hospital within 24 hours Fo the Funeral	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a cone 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		. ,	
F 3 - 8	M	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d Date signed (M	onth, Day, Year)
		30. Name and address of person who complete deause of death (Item 23a)			
		Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 31. Date filed (Month, Day, Year) 32. Rapistrar's Signature	21201		
S Regis	tate trar	MAY 3 1 2006 Research M. Joseph			
DHMH 17 Rev 1/2	2001	ORIGINAL		 -	

06-03478

Please Type or Print in Black Indelible Ink

Sandra Moody		State of Maryland / Department of Health and Mental Hygiene - For State Certificate of Death - For State Reg. No. 2 1 1 5	699
Physicia	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of the destrict of the des	
Medical Examin		Sandra D. Moody May 22, 2006 Year 1623 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death	nis
Farmeral		University Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (St	ate or
Funeral Director	9	219-76-4703 1 M 2 F 57 Yrs. Months Days Hours Min July 3, 1948 Foreign Country) 4	d.
м апу	-		de City Limits
with the Maryland ms 23a or 28a-f show be notified at once.	ector	10é. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
aith the N 23a or 10tified	a Dr	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian	. Black.
er death v	Funeral Director	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No Specify: Specify: Specify:	
hours aft natural" Examine	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	
5-0036 ed within 72 tygiene other than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Disable d Disable d	
should be filed within 7 and Mental Hygiene 7 is marked other than natic event, the Medicanatic	Be Co	17. Father's Name (First, Middle, Last) [
Should and Me 7 is man matic ex	의	19a. Infor Int's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Tean Clark 405 Lyndhurst St. Balto, Ud. 212	229
nore, MC ages and 2 s nt of Health an it: If item 27		20a Method of Disposition 20b. Place of Disposition Name of cemetery, crematory or other place) Trivity Cem. Date 20c Location - City or Town, Start Crematory or other place) Trivity Cem.	ie
Baltimore, permit. Pages I at Department of He Important: If ite	1	4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee Name and Address of Facility Ouglass Funeral Service Name and Address of Facility Ouglass Funeral Service	PA
Physician /Medical		failure. List only one cause on each line.	mate Interval in Onset and
xaminer		or condition resulting in death) Due to (or as a consequence of):	Death
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	
d	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	
tox 68760, each certificate be executed a attending physician and for use as the burial - transit	lical E	X UNPENDED item#23a-b,PII,27,28a-f,perME,g860, 10/3/06 TT	
8760, ifficate be paysic to the buri		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 3 Fedal death 3 Fedal death 3 Month Day	Year
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transil	ysicia	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
ords, P.O. B w requires that the d s been signed by the	δ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause Hypertension; mental retardation; diabetes mellitus 1 Yes 2 No 3 Probably 4	- 5
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death al Director: After this certificate has been signed by led in by the flueral director, page 2 should be detach	ompleted	24a Was an 24b Were autopsy finding autopsy prior to completion	
tal Records cian: The law requi certificate has been ector, page 2 should	OL	performed? death? 1 Ves 2 No 1 Ves 2	No No
Vital hysician:	o Be	25. Was case referred to medical examiner? 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other Other Nursing Home 5 Residence 6 Other	
n of V ing Phy After th	\vdash	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
ivision or Attendi after death Director:	atio	Natural 5 Pending Pending S/22/2006 unk 1 Yes 2 X No unk	
Divis ospital or A hours after meral Dire	Certification:	3 Suicide 6 X Could not be determined (Specify) University Specialty Hospital 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 601 S. Charles S Baltimore, MD	t.
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director. page	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
9	Me	29b Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Ye) O.C.M.E. May 23, 2006	ar)
3		30. Name and address of person who completed eadse of death (Item 23a)	
9	ate	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month, Day, Year) 32. Registrar's Signature	
Regist		MAY 3 1 2006 George & Courte	
DHMH 17 Rev 1/20	001	ORIGINAL	

GARY Lec Mitchell

		1 Stete	State of Ma			of Health and	d Mental Hy	/giene	
		Registrar 1. Decedent's Name (First, Middle, L	(128)		Certificate	of Death	2. Date of De	Reg. No.	5 17001
Physic							Month	Day Yea	NA AA
/Med Exami		Gale Lee Mitch 4a. Facility Name (If not institution, gi			4b. City, To	wn, or Location of De	May 2	6, 2006 4c. County of De	3:40 A
		Hart Heritage			Stree			Harford	
Funeral		Social Security Number 6.	Sex 7. Age	e (In yrs. last birthe	day) If Under 1 \				Firthplace (State or Foreig Country)
Director		212-28-3703 Usual Residence of Decedent	A W ZU F	79 ^{Yr}	S.	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2, 1926 We	st Virginia
land ow		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
72 hours after death with the Maryland natural', or Itams 23a or 28a-f show dical Evant at must be a diffect at	tor	Maryland Harfor	rđ	Bel Ai	r				1 ☐ Yes 2 🛱 No
th the	irec	10e. Street and Number			10f. Zip Co	ode		10g. Citizen of What (Country?
be filed within 72 hours after death with the Maryla ital Hygiene. id other than "natural", or Itams 23a or 28a-f shov avant, the Medical Exameter must be indiffed at	Funeral Director	1801 Ruffs Mill	Road		210	15		USA	
tams	nue	11. Marital Status	12. Was Decedent E Amed Forces?		13. Was Deceden If Yes, specify	t of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No		
rs affe	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 23	40	1 Yes 2			Specify:	me, etc.
tural stural	edt	15. Decedent's E	Year or Dates:	16a D	ecedent's Usual C				White
within 7% ene. than "na his Medi	Completed	(Specify only highest gi	rade completed) College (1-4or 5		Give kind of work of fe. DO NOT use r	done durina most of w	vorking	100. Kind of Busines	s/industry
filed with Hygiene. other than	Son	8	College (1940) 3		nstructio	on Worker		Gas	
be file fal Hy id oth avant	Be (17. Father's Name (First, Middle, Las	(t)			18. Mother's N	ame (First, Middle	, Maiden Sumame)	
should be ind Mental I marked o	은	Arthur (nmn)				Carrie	1	-,	
d 2 sh h and 7 tsm traum		19a. Informant's Name/Relationship						er, City or Town, State,	
es 1 and 2 should b of Health and Ment fitam 27 is markad r othar traumatic a		Blanche Andrews 20a. Method of Disposition	- Friend	20b. Place of D	01 Ruffs isposition (Name o	Mill Road	, Bel Ai	r, Maryland	21015
rages nert of h int: If its		1 Burial 2 ☐ Cremation 3 [☐Removal from State	cemetery,	crematory or other	r place)	Date	20c. Location - City o	r Town, State
- 돈 뿐 글		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Bel Ai	Mem. Ga			Bol Air, N	
Depa Impo any ir		A Russell Ster	_				McComas 1	Funeral Hom	ne, P.A.
		23a. Part1. Enter the disease, or con	nplications that caused	the death. Do not	enter the mode of	dying, such as cardi	ac or respiratory a	Bel Air, MC	Approximate
Physician		Immediate Cause (Final	/ one cause on each lin	I 0 .					Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a	a consequence of):	1 () P	usplasor	~		yenns
Examiner		Sequentially list conditions,	b						
pi ji	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence of):					
and I-fransit	xamin	that initiated events resulting in death) Last	C. Due to (or as a	annonumen of					
ba exercian ar	al Ex		Due (0 (0) as a	a consequence of):					
physics the I	dic		_ d						
ine law requires that the death cartificate be exite has been signed by the affending physician a sage 2 should be defached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy				004 0-4-4	
a affe	iciai	in the past 12 months?	1□Live birth 2 4□Pregnant at t		3 ☐ Ectopic pregn. 5 ☐ Other (specific			23d. Date of de Month	Day Year
ad by the affe	hys	9 Unknown	9□ Unknown						
w requires man been signad t should be def	by P	Part II. Dther significant conditions	contributing to death bu	t not resulting in th	e underlying cause	given in Part I.	23e. Did to	obacco use contribute to	o the cause of death?
en sii							1 🗆 Y	res 2□No 3□P	robably 4 Unknown
has be	Completed						24a. Was		utopsy findings available
	Con						autop perfor	rmed? prior to death? 2 No 1 Yes	completion of cause of 2 □ No
or,	Be (25. Was case referred to medical examiner?				26. Place of De	eath (Check only of	•	acci ched
ic eri	2	1 ☐ Yes 2 🔯 No	Hospital: 1 ☐ Inpatien	The second second	Harit 3 DOA	Other: 4 Nursing	Home 5 ☐ Resid	lence 6 Other (Spe	icity) core
d is	ë	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injur	e of 28c. 1	njury at Work?		ow injury occurred	
d is	0	2 ☐ Accident investigatio				1 ☐ Yes 2 ☐ No			
d is	icatio	3 ☐ Suicide 6 ☐ Could not b	286. Place of Injur	ry - At home, farm, (Specify)	street, factory, off	ice	28f. Location (S City or Tow	itreet and Number or Ru n, State)	ural Route Number,
death. ctor: Affer this y the funeral di	ertificatio	3 Suicide 6 Could not be determined	building, etc.				1		
death. ctor: Affer this y the funeral di	Il Certification:	4 Homicide determined	building, etc.	my knowledge de	- ash	a Constant and a second			
death. ctor: Affer this y the funeral di		4 Homicide determined	hysician: To the best of miner: On the basis of e	Skallillation and of	eath occurred at the investigation, in n	e time, date and plac ny opinion, death occ	e, and due to the durred at the time, o	ause(s) and manner as date and place, and due	s stated. to the cause(s)
death. ctor: Affer this y the funeral di	Medical Certificatio	4 Homicide determined	building, etc.	Skallillation and of	investigation, in n	e time, date and plac ny opinion, death occ ense number	urred at the time, o	cause(s) and manner as date and place, and due 29d. Date signed (Monti	to the cause(s)
death. ctor: Affer this y the funeral di	edical	4 Homicide determined 29a. Certifier (Check only one) Check only one) determined determined	hysician: To the best of miner: On the basis of e	Skallillation and of	investigation, in n	ense number	urred at the time, o	date and place, and due	h, Day, Year)
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Registrar DHMH 17 Rev 1/2001